

200099

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

95 20212

8 REG. NO.

20212

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Everett S. Bailey</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 10, 1985</b>			2b. HOUR <b>12:15 PM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 19 1922</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford</b> MD.			
10. CITY OR TOWN OF DEATH <b>Harre de Geage</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Harford Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Train Dispatcher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O Railroad</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Cecil</b>		13c. CITY OR TOWN <b>Perryville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>632 Charles St. 21903</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William S. Bailey</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Estella Riley</b>				ADDRESS <b>P.O. Box 162</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. GIVE WAR OR DATES <b>WW II</b>		17. SOCIAL SECURITY NO. <b>216-16-9075</b>		17. INFORMANT <b>J. Earlene Bailey 632 Charles St. 21903</b>			
18. CAUSE OF DEATH Enter only one cause per line (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cardiomyopathy</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>① Acute and chronic renal Failure ② Diabetes mellitus ③ Hypertension</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>7/14</b> , 19 <b>76</b> , to <b>7/10</b> , 19 <b>85</b> , that (I) (most) last saw the deceased alive on <b>7/10</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (did) (did not) view the body after death.									
22b. SIGNATURE <b>W. Kim</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>7/10/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SANGT W. KIM</b>				22e. ADDRESS <b>308 S. Union Ave. Harre de Geage, MD 21028</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 13, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mark's Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Perryville Cecil Maryland</b>			
24. BURIAL DIRECTOR <b>Lee A. Patterson &amp; Son P.O. Box 188 21903</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 12 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

Jan 11	21-10-2027	3. Contine Golden 875 Charles St. 2123	8. U. or 102	875 Charles St. 2123	Jan 11 1922
William	2.	Golden	Golden	Golden	Golden
Land	(Gold)	Peninsula	X	875 Charles St. 2123	Golden
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Lee H. Jackson & Son P.O. Box 18 2123  
 13, 1827 4. Contine Golden 875 Charles St. 2123  
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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8 5 2 0 2 1 3

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>William Henry Barclay</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>July 4, 1985</u>		2b. HOUR AM PM <u>9:45 A</u>		
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>Jan. 19, 1927</u>		6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS <u>58</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Harford</u> MD.	
10. CITY OR TOWN OF DEATH <u>Havre de Grace</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Harford Memorial Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Laborer/Ret. Army</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Maryland</u>		13b. COUNTY <u>Harford</u>		13c. CITY OR TOWN <u>Havre de Grace</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <u>c/o 243 Bloomsbury Ave./21078</u>		14. FATHER'S NAME FIRST MIDDLE LAST <u>Vernon Barclay</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Florence Barclay</u>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Yes</u>	
16b. SOCIAL SECURITY NO. <u>215-22-9295</u>		17. INFORMANT <u>Darlene Glendening</u>		ADDRESS <u>Havre de Grace, MD 243 Bloomsbury Ave./21078</u>		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cerebrovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus</u>	
19a. DATE OF OPERATION <u>8/10/85</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>hypertensive arteriosclerotic cardiovascular disease</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death.	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22b. SIGNATURE DEGREE <u>SANG W. KIM</u> 22c. DATE SIGNED <u>July 4, 85</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Jul 8, 1985</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baker Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Aberdeen, Harford, Maryland</u>	
24. FUNERAL DIRECTOR NAME <u>Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399</u>		25a. DATE REC'D. BY REGISTRAR <u>JUL 10 1985</u>		25b. REGISTRAR'S SIGNATURE <u>Sally Davidson-Randall</u>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 REG. NO. 20214

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT) <b>Pauline Theresa Berme1</b>			7a. DATE OF DEATH MONTH DAY YEAR <b>07-31-85</b>			7b. HOUR <b>1P.</b> M.			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>AUG. 6, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE COUNTRY <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HARFORD COUNTY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BEL AIR</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BEL AIR CONV. HOME</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MD.</b>			13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE <b>6710 HAVEN OAK ROAD 21237</b>			14. FATHER'S NAME FIRST MIDDLE LAST <b>CHARLES EBER</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY E. KARL</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>215-32-4389</b>		17. INFORMANT ADDRESS <b>FAMILY RECORDS</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Left Anterior Septal Cardiac Vascular Disease and Hypertensive Aortic</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Disease</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 WK</b> <b>10 YR</b> <b>10 YR</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <b>Arteriosclerosis</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>11/2/82</b> , 19____, to <b>7/31/85</b> , 19____, that (I) (we) lost saw the deceased alive on <b>7/29</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Dudley, Phillip M</b> DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/31/85</b>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DUDLEY Phillip M</b>						22e. ADDRESS <b>Box 300 D Arlington Md 20034</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>8-3-1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO CITY, MD.</b>		
24. FUNERAL DIRECTOR <b>EVANS CHAPEL OF MEMORIES</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 5 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Jane Davidson-Randall</b>	

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7-31-85 item 13 L.J

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5

REG. NO.

2 0 2 1 5

1. DECEASED NAME (TYPE OF PRINT) FIRST MIDDLE LAST <b>ALBERT H. BERRY</b>				2b. DATE OF DEATH MONTH DAY YEAR <b>7 2 85</b>		2c. HOUR <b>1:55 PM</b>	
3. SEX <b>M</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 10 1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HARFORD</b> MD.	
10. CITY OR TOWN OF DEATH <b>FALLSTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FALLSTON GENERAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Laborer</b>		13a. STATE <b>Md.</b>		13b. COUNTY <b>Harford</b>		13c. CITY OR TOWN <b>Frosthill</b>	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1270 W. Jarrettville 21084</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Albert Henry Berry</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Martha Cornish</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-18-1300</b>		17. INFORMANT <b>George Berry 1270 W. Jarrettville Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>BACTERIAL ENDOCAUSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CONGESTIVE HEART FAILURE</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b> <b>DAYS</b> <b>YEARS</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <b>AORTIC VALVE DISEASE (YEARS)</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>1270 W. Jarrettville 21084</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>6/28</b> 19 <b>85</b> , to <b>7/2</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>7/2</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) witness the body's death.							
22a. SIGNATURE <b>BARRY WOHZ</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>7/2/85</b>	
22b. PHYSICIAN'S NAME (TYPE OF PRINT) <b>BARRY WOHZ</b>				22e. ADDRESS <b>2003 ROCKSPRING RD. FOREST HILL MD 21050</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-6-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Chestnut Grove</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Harford Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Arnold W. Beard 353 Fountain St. Hdg. Md.</b>				25a. DATE REC'D BY REGISTRAR <b>JUL 10 1985</b>			
				25b. REGISTRAR'S SIGNATURE			

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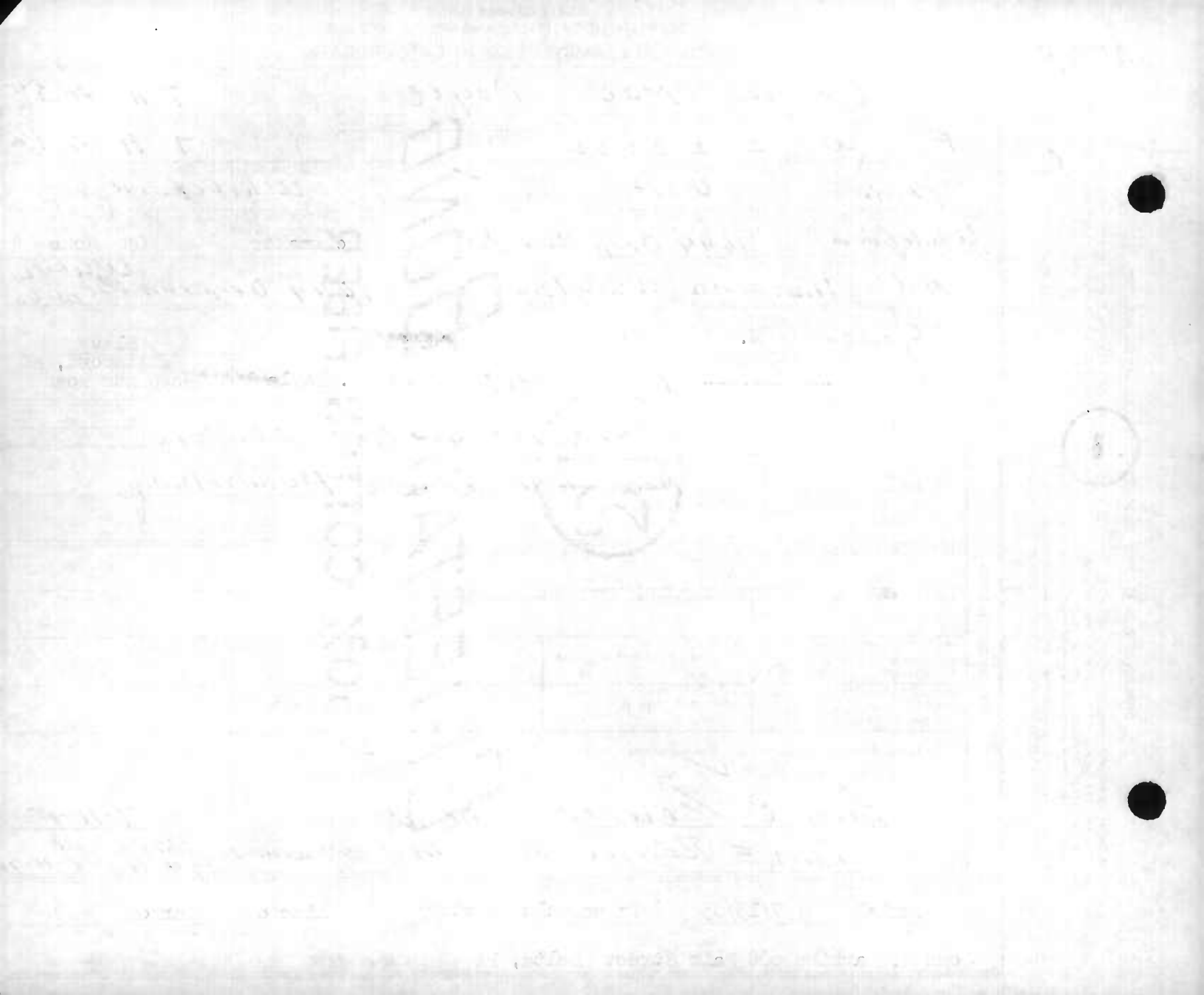
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 0 0 2 1 6	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Georgia Mae Boyle</i>										20. DATE KNOWN OF DEATH MONTH DAY YEAR <i>7 11 85</i>	
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>2 2 23</i>		6. AGE (IN YEARS) LAST BIRTHDAY <i>62</i> YRS.	IF UNDER 1 YR. MONTHS DAYS <i>0 0</i>	IF UNDER 24 HRS. HOURS MIN. <i>0 0</i>	21. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>7 11 85</i>		22. HOUR <i>5:45</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Tenn</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Whiteford Harford CO. MD.</i>				
10. CITY OR TOWN OF DEATH <i>Whiteford</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>1644 Deep Run Rd</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>			
13a. STATE <i>MD</i>		13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Whiteford</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>1644 Deep Run Rd</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>George W. Miller</i>					15. MOTHER'S MAIDEN NAME MIDDLE LAST <i>Mattie Slavy</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>178-22-9357</i>		17. INFORMANT NAME ADDRESS <i>Samuel L. Boyle 1644 Deep Run Road</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiorespiratory Failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>Major Neurodegenerative Muscular Dystrophy</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Luis E. Renjel</i>				TITLE (SPECIFY) <i>MD. Deputy</i>				DATE <i>7-11-85</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>LUIS E. RENJEL MD</i>				ADDRESS <i>464 Williams St Harford</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>7/15/85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Tabernacle Cemetery</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>Whiteford Harford MD</i>			
24. FUNERAL DIRECTOR NAME ADDRESS <i>John H. Harkins 600 Main Street Delta, PA</i>						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>John H. Harkins</i>			

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))



211016

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 20217

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR					
Bernard Louis Brockmeyer						7-25 19 85			10 44								
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d. HOUR					
M	W	1 12 27	58 YRS.			7-25 19 85			10 58								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			NEVER MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH					
Md			USA			WIDOWED			DIVORCED			Harford MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Fallston			Fallston General Hospital			Plumber			Plumbing								
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE			13b. CITY OR TOWN			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
MD			Harford			Jarrettsville			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Jarrettsville MD. 21084					
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME											
Charles Brockmeyer						Mary Huber											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?						16b. SOCIAL SECURITY NO.						17. INFORMANT					
Yes						WW II						Jarrettsville, Md. Mrs. Dorothy Murray 3761 Jarrettsville Pike					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE TIME BETWEEN ONSET AND DEATH					
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) CORONARY HEART DISEASE																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																	
(b) ASCVD																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?					
												YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
						HOUR A.M. MONTH DAY YEAR											
21d. INJURY OCCURRED						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>												STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE						TITLE (SPECIFY)						DATE SIGNED					
Luis E. Renjel						Deputy						7-25-85					
EXAMINER'S NAME (TYPE OR PRINT)						ADDRESS											
Luis E. Renjel, M.D.						464 Alliance St. Havre De Grace, MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION							
Burial				7/29/85		St. Joseph Cemetery				Baltimore Md.							
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR						REGISTRAR'S SIGNATURE					
SCHIMUNEK FUNERAL HOME, INC. 9705 Belair Rd., Balto. Md. 21236						JUL 26 1985						John A. ...					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 0 2 1 8

1- FOR  
STATE  
REGISTRAR

DECEASED NAME (TYPE OR PRINT) <b>Francis John Bullock</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 23, 1985</b>		2b. HOUR <b>3:30pm</b>
3 SEX <b>Male</b>	4 RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>April 26, 1916</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Harford County</b> MD.	
10 CITY OR TOWN OF DEATH <b>Forest Hill</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2708 Harriet Lane 21050</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Millwright</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Telephone Cable Mfr.</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Harford</b>	13c. CITY OR TOWN <b>Forest Hill</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>2708 Harriet Lane 21050</b>
14 FATHER'S NAME FIRST MIDDLE LAST <b>Edwin Bennett Bullock</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Elizabeth Krepp</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II 216.03.0420</b>		17 INFORMANT ADDRESS <b>Mazie F. Bullock Same as 13e</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Advanced Met Carcinoma of Prostate</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>with Ben-Bony Nephrosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>HA SCVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>March</b> , 19 <b>72</b> , to <b>July 23, 1985</b> , that (I) (we) last saw the deceased alive on <b>6-24-85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Muri Mathor M.D.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>7-23-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MURLI MATHOR, M.D.</b>		22e. ADDRESS <b>1305 Fallston Road Fallston, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/27/1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>		23e. DATE RECD. BY REGISTRAR / REGISTRAR'S SIGNATURE <b>JUL 25 1985</b>			
24. FUNERAL DIRECTOR NAME <b>Walter Brooks Bradley, Inc. Balto., MD 21222</b>					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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JOE

193047

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 20219

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		10:52 <sup>AM</sup>	
Wallace I. Burdick		7-2-85			
3 SEX	4 RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Male	WHITE	MONTH DAY YEAR	65 YRS.	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
New York	U.S.A.		Hartford Co MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Fallston	Fallston General Hospital		Solon Inc.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13e. STREET ADDRESS / ZIP CODE		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
MD	Baltimore	PERRY HALL	10 Tabor Pl 21236		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Charles J. Burdick		HARRIST		Nail	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS	
YES		W.W.J. 126099727		FAMILY RECORDS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) _____					
DUE TO, OR AS A CONSEQUENCE OF _____					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____					
DUE TO, OR AS A CONSEQUENCE OF _____					
(c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (b)					
Chronic renal failure					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) lost saw the deceased alive on _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE	
		MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
L. F. E. K. C. H.		1604 Churchville Road			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		JULY 5, 1985		PARKWOOD Cem.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REG. CLERK		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS		JUL 05 1985			
EVANS CHAPEL OF MEMORIES HARTFORD ROAD					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in order that a post-mortem examination may be required.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8 5 2 0 2 2 0

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Milton H. Burkindine			2a. DATE OF DEATH MONTH DAY YEAR July 14 1985		2b. HOUR 8:21 AM			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR APRIL 8, 1916		6. AGE [IN YEARS (LAST BIRTHDAY)] 69 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.		
10. CITY OR TOWN OF DEATH Laurel de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (RET) MAIN. SUPERV.		12b. KIND OF BUSINESS OR INDUSTRY (APG) FED GOVT		
13a. STATE Md.			13b. COUNTY Harford		13c. CITY OR TOWN Churchville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 3519 Level Rd. 21028								
14. FATHER'S NAME FIRST MIDDLE LAST FREDERICK H. BURKINDINE			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA STEWART					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 215-10-9460		17. INFORMANT ADDRESS MRS. MARIE T. BURKINDINE SAME AS #13e				
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CAD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCVD</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>7-11</u> 19 <u>85</u> , to <u>7-14</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>7-14</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE J. T. Lee		22c. PHYSICIAN'S NAME (TYPE OR PRINT) J. T. Lee		22d. ADDRESS Annon Med. Clinic, Laurel de Grace		22e. DATE SIGNED JUL 16 1985		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 17 JULY 85		23c. NAME OF CEMETERY OR CREMATORY HARFORD MEMORIAL GARDENS		23d. LOCATION CITY OR TOWN COUNTY STATE ALDINO, HARFORD CO, MARYLAND		
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL FUNERAL HOME, PA, HAVRE de GRACE, MD. 21078				25a. DATE REC'D. BY REGISTRAR JUL 16 1985				
				25b. REGISTRAR'S SIGNATURE John Davidson-Randall				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100487



100487





212011

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards on pages 1 and 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SELMA A. BUTT						2a DATE OF DEATH MONTH DAY YEAR 07-20-85		2b HOUR A M 3:50 A	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 9 12 1896		6 AGE (IN YEARS LAST BIRTHDAY) 88		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN.	
8a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Phila. Penna.		8b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City Harford MD.			
10 CITY OR TOWN OF DEATH Baltimore Harford		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Belair Convalesarium				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY Homemaking	
13a STATE Maryland		13b COUNTY Harford		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE Belair Convalesarium 21014	
14 FATHER'S NAME FIRST MIDDLE LAST Goritsky				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b SOCIAL SECURITY NO. 216-32-9228		17 INFORMANT ADDRESS Ruth H. Glenn 5603 Kenwood Ave. 21206			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION (STREET CITY OR TOWN COUNTY STATE)					
22 I certify that (1) this deceased attended the deceased from 05-23 19 83 to 07-20 19 85 that (1) I first saw the deceased on 07-18 19 85 and that in (my) opinion death occurred on the date and hour and from the causes stated above (2) I saw the body after death.									
22a SIGNATURE [Signature]				DEGREE		22b DATE SIGNED 7/20/85		22c ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS Baltimore, Maryland					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 7-23-85		23c NAME OF CEMETERY OR CREMATORY St. John Ev. Luth Ch. Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Howard Maryland			
24 FUNERAL DIRECTOR NAME Cassidy FH 7401 Belair Rd				25a DATE REC'D. BY REGISTRAR JUL 25 1985		25b REGISTRAR'S SIGNATURE Julia Davidson-Randall			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2 0 2 2 2

1. DECEASED NAME (TYPE OR PRINT) <b>Milton I. Canter</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>7-4 1985</b>		2b. HOUR <b>2:25 P.M.</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>4-18-1932</b>	6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>53</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>7-4 1985</b>		2d. HOUR <b>2:25 P.M.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford County, MD.</b>			
10. CITY OR TOWN OF DEATH <b>Jarrettsville</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>rear of 4135 Madonna Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Psychologist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Balto. Dept. of Education</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Md.</b>	13b. COUNTY <b>Harford</b>	13c. CITY OR TOWN <b>Madonna</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>4135 Madonna Rd.</b>		13f. ADDRESS <b>of Education Jarrettsville, Md. 21084</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Milton A. Canter</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE <b>Annabelle Detzer</b>		16. SOCIAL SECURITY NO. <b>213-28-9264</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. (IF YES, GIVE WAR OR DATES) <b>Army Korea</b>		17. INFORMANT ADDRESS <b>Mrs. Charlotte E. Canter 4135 Madonna Rd. Jarrettsville, Md. 21084</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shotgun Wound of Chest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? (chest only) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>? P.M. 7-4 1985</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>subject shot himself</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>back yard</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>4135 Madonna Rd., Jarrettsville, Harford Co., Md.</b>					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Margareta Be Gull</b>		TITLE (SPECIFY) <b>M.D. Assistant</b>		MEDICAL EXAMINER		DATE SIGNED <b>7-5-85</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>		ADDRESS <b>111 Penn St., Balto., Md. 21201</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-6-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>John C. Miller Inc-6415 Belair Rd.-21206</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 05 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Samuel A. Wilson-Randall</b>			

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 REG. NO. 20223

1. DECEASED NAME (TYPE OR PRINT) <b>MAZIE CHANDLER</b> MIDDLE <b>LOU</b> LAST <b>CHANDLER</b>		2a. DATE OF DEATH MONTH <b>7</b> DAY <b>1</b> YEAR <b>85</b>		2b. HOUR <b>545 P.M.</b>
3. SEX <b>F</b> Female	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH <b>June</b> DAY <b>9</b> YEAR <b>1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford County</b> MD.
10. CITY OR TOWN OF DEATH <b>Fallston</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Fallston General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>--</b>

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>133 Thomas Street 21014</b>
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Harford</b>	13c. CITY OR TOWN <b>Bel Air</b>	
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>Andrew</b> LAST <b>Suite</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Cora</b> MIDDLE <b>Lee</b> LAST <b>Pilkins</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>	16b. SOCIAL SECURITY NO. <b>212-20-5597</b>	17. INFORMANT ADDRESS <b>Md. 21014 Mrs. Dorothy Reedy, 210 Richardson St, Bel Air</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio respiratory Failure</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Narrow Intracerebral bleed</b>		
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertension</b>		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **--**

19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR <b>A.M.</b> MONTH <b>19</b> DAY <b>19</b> P.M.	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET <b>1131 Bel Air Rd</b> CITY OR TOWN <b>Bel Air</b> COUNTY <b>Harford</b> STATE <b>MD</b>		
22a. I certify that (I) (this hospital) attended the deceased from <b>6-26-1985</b> to <b>7-1-1985</b> , that (I) (we) last saw the deceased alive on <b>7-1-1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>A. Shok</b>		DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/1/85</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ASHOK</b>		22e. ADDRESS <b>NARANG 1131 Bel Air Rd, Bel Air, MD 21014</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>July 5, 1985</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens</b>	23d. LOCATION CITY OR TOWN <b>Bel Air</b> COUNTY <b>Harford</b> STATE <b>MD</b>
24. FUNERAL DIRECTOR NAME <b>Howard K. McComas III</b> ADDRESS <b>Abingdon, Md. 21009</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 03 1985</b> 25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

922

CHAMBER

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## DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 20224

1. DECEASED NAME (TYPE OR PRINT) Elmer Leroy Cochran			2a. DATE KNOWN OF DEATH X MONTH DAY YEAR 7/ 5/ 19 85			2b. HOUR 2:50 P M		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 10, 1938	6. AGE (BY YEARS LAST BIRTHDAY) 46 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD 7/ 5/ 19 85		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County, MD.		
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Various
13a. STATE Pennsylvania		13b. COUNTY York	13c. CITY OR TOWN Peach Bottom		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 222, Box 1980 99999	
14. FATHER'S NAME FIRST MIDDLE LAST Farley M. Cochran			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alpha L. Wagner					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		(IF YES, GIVE WAR OR DATES) Korea		16b. SOCIAL SECURITY NO. 214-36-8858		17. INFORMANT ADDRESS Chas. Cochran, Box 175, Conowingo, MD 21918		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 7102 IMMEDIATE CAUSE (a) Drowning DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Acute Ethanolism								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:26 PM 7/5/19 85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject drowned while swimming			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) marina		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Joppatown Marina, Joppa, Md.			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.			TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER			DATE SIGNED 7/7/85		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE July 9, 1985		23c. NAME OF CEMETERY OR CREMATORY Highview Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Fallston, Harford, Maryland	
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399			25a. DATE REC'D. BY REGISTRAR JUL 10 1985		25b. REGISTRAR'S SIGNATURE L. Friedman-Randall			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

8 REG. NO. 20225

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		6. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
HENRY		CUMBERLAND		7-27-85		11:38 AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
M		W		6 25 1897		88 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Balto. Md.		U. S. A.				Harford Co.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Fallston		Fallston Gen. Hos. Fallston, Md.		Supervisor		Beth. Steel			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS / ZIP CODE			
Maryland		Harford		Fallston		2055 Durham Rd. 21047			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
John Henry Cumberland		Margaret Kellner		no		213 07 6841		2055 Durham Rd. Fallston, Md. 21047	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		CARDIO-PULMONARY ARREST.		SEPTICEMIA DECUBITI		DEHYDRATION, ANAEMIA ASCED			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		RENAL FAILURE							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7-25-1985, to 7-27-1985, that (I) (we) last saw the deceased alive on 7-26-1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE M.D.		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
ABDUL G. GURESHY		4806-YORK RD. BALF. MD. 4212							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		July 30, 1985		Sacred Heart of Jesus		Dundalk Baltimore Md.			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
E.F. Lassahn, 11750 Belair Rd. Kingsville, Md. 21087									

BP \_\_\_\_\_

10718



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 85 20226

1- FOR  
STATE  
REGISTRAR

191040

1. DECEASED NAME (TYPE OR PRINT) **Marguerite Evelyn Davies**  
**MARGUERITE EVELYN DAVIES**

2a. DATE OF DEATH MONTH DAY YEAR **07 04 85** 2b. HOUR **6:29** M

3. SEX **Female** 4. RACE **White** 5. DATE OF BIRTH MONTH DAY YEAR **April 17, 1914** 6. AGE (IN YEARS LAST BIRTHDAY) **71** YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) **Corning, Missouri** 7b. CITIZEN OF WHAT COUNTRY? **USA** 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH **HARFORD COUNTY** MD.

10. CITY OR TOWN OF DEATH **FALLSTON** 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) **FALLSTON GENERAL HOSPITAL** 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) **Bakery Worker** 12b. KIND OF BUSINESS OR INDUSTRY **Acme Stores**

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE **Maryland** 13c. CITY OR TOWN **Harford** 13d. CITY OR TOWN **Joppatown** 13e. INSIDE CITY LIMITS? YES ☒ NO ☐ 13f. STREET ADDRESS / ZIP CODE **515 Eckhart Drive 21085**

14. FATHER'S NAME (FIRST MIDDLE LAST) **William Jess Bush** 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) **Lee Oral Wilson**

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) **no** 16b. SOCIAL SECURITY NO. **217-07-5838** 17. INFORMANT ADDRESS **Washington, DC 20015**  
**Robert W. Deller, 5447 Chevy Chase Pkwy N.W.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **Cardiopulmonary Arrest**  
DUE TO, OR AS A CONSEQUENCE OF (b) **General debilitation**  
DUE TO, OR AS A CONSEQUENCE OF (c) **Metastatic adenocarcinoma**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☒ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 **6/17/85** 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) **7/4/85**

21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE **Fallston Gen Hospital**

22a. I certify that (1) this hospital attended the deceased from **7/13/85** to **7/14/85** that (1) (we) last saw the deceased alive on **7/13/85**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) did not view the body after death.

22b. SIGNATURE **Robert Smith** DEGREE 22c. DATED **7/14/85**

22d. PHYSICIAN'S NAME (TYPE OR PRINT) **Robert Smith** 22e. ADDRESS **Fallston Gen Hospital**

23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) **Burial** 23b. DATE **July 6, 1985** 23c. NAME OF CEMETERY OR CREMATORY **Meadowridge Mem. Park** 23d. LOCATION **Dorsey** **Howard** **Md.**

24. FUNERAL DIRECTOR NAME ADDRESS **Howard K. McComas III, Abingdon, Md. 21009** 25a. DATE REC'D. BY REGISTRAR **JUL 8 1985** 25b. REGISTRAR'S SIGNATURE **John E. Deller**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

01010



*[Faint, illegible handwritten text, possibly a signature or note, located in the center of the page.]*

*[Faint, illegible handwritten text at the bottom of the page, possibly a date or another signature.]*

213105

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM. 3. RETURN PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 0 2 2 1

1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH		2b. DATE OF DEATH		2c. DATE PRONOUNCED DEAD		2d. HOUR			
DECEASED NAME (TYPE OR PRINT) CARRIE LEE DOWELL										X July 27 1985		July 27 1985		July 27 1985		3 AM			
1. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		7d. HOUR					
Female		White		Dec. 29 1931		53 YRS.						July 27 1985		M					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
Virginia				U.S.A.								Harford MD							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Forest Hill				2420 Johnson Mill Road				Housewife				Home							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
13a. STATE		13b. CITY		13c. CITY OR TOWN		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				21050 a@a Johnson Mill Road									
Maryland		Harford		Forest Hill															
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME									
June Nickols										Juanita Hale									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)										16b. SOCIAL SECURITY NO.									
NO										NONE 213-30-9480									
17. INFORMANT										2420 Johnson Mill Road Forest Hill, Maryland									
Mack B. Dowell																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) <i>Carcinomatosis - C.R. failure</i>																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																			
(b) <i>Ca of liver</i>																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																			
19a. DATE OF OPERATION								19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
																YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
				HOUR A.M. MONTH DAY YEAR															
				P.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION											
								STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																			
TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER DATE SIGNED 7-28-85																			
ACTUAL SIGNATURE <i>L. E. Renjel</i>																			
EXAMINER'S NAME (TYPE OR PRINT) Luis E. Renjel ADDRESS 464 Alliance St. Havre de Grace, Md.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION				COUNTY		STATE			
Burial				7-30-85		New Bridge Baptist				Rising Sun				Cecil		Md.			
24. FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Howard K. McComas III Abingdon, Maryland										JUL 30 1985		<i>Julia Davidson-Randall</i>							

RECEIVED  
FEB 10 1954  
U.S. AIR FORCE  
HEADQUARTERS  
WASHINGTON, D.C.

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FEB 10 1954  
U.S. AIR FORCE  
HEADQUARTERS  
WASHINGTON, D.C.

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WASHINGTON, D.C.

RECEIVED  
FEB 10 1954  
U.S. AIR FORCE  
HEADQUARTERS  
WASHINGTON, D.C.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 REG. NO. 20228

218144

1 - FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
		Emory Charles Fletcher		7/28/85		11:52 a.m.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE	
M		W		11 09 99		85	
7a. BIRTHPLACE		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		USA				Harford MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY	
Jarrettsville		3930 Old Federal Hill Rd.		Dairy Farmer		Farming	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13e. STREET ADDRESS / ZIP CODE	
Maryland		Harford		Jarrettsville		3930 Old Federal Hill Rd. 21084	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES?		17. INFORMANT	
Jehu Franklin Fletcher		Sarah Ellen McRoy		No		Ruth L. Fletcher same as above	
18. CAUSE OF DEATH		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (b) Severe dehydration & malnutrition DUE TO, OR AS A CONSEQUENCE OF (c) PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
		HOUR A.M. MONTH DAY YEAR P.M. 19		(ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		22c. DATE SIGNED	
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		(AT HOME STREET FACTORY OFFICE FARM ETC.)		CITY OR TOWN COUNTY STATE		7/29/85	
22a. I certify that (I) (this hospital) attended the deceased from 7/18/85 to 7/28/85, that (I) (we) last saw the deceased alive on 7/18/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. ADDRESS		22d. PHYSICIAN'S NAME	
		Brian T. Yeo M.D.		801 S. Union Ave., Havre de Grace, Md. 21078		Brian T. Yeo, M.D.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		7/31/1985		St. Paul		Pylesville, Harford, Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S NAME	
M. Gladden Kurtz Jarrettsville, Md.		AUG 02 1985		[Signature]		i	



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



217008

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the following pages: 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 REG. NO. 20229

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>GERALDINE FORSHA</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>07-28-85</b>		2b. HOUR MIN. <b>11<sup>14</sup> A</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>09 20 90</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>94</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Hartford County</b> MD.	
10. CITY OR TOWN OF DEATH <b>FALLSTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FALLSTON GENERAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Homemaker</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>Hartford Co.</b>		13c. CITY OR TOWN <b>DARLINGTON</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Washington Troutman</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lydia Eicher</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>169-07-3837</b>	
17. INFORMANT (Daughter) <b>Mrs. Martha S. Bodcombe</b>		18. ADDRESS <b>457-5526 2336 Castleton Road Darlington, Maryland 21034</b>		19. DATE OF OPERATION <b>July 29, 1985</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Long standing heart failure seen.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Renal failure</b>		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <b>July 28, 1985</b> to <b>July 29, 1985</b> , that (I) (we) lost saw the deceased alive on <b>7/27</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <b>Randall C. Cronin, Jr.</b>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT)		22c. ADDRESS		22d. DATE SIGNED <b>7/28/85</b>		22e. DEGREE <b>MD</b>	
22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22g. ADDRESS <b>721 Wheeler School Rd. Whitefish, Md.</b>		22h. DATE SIGNED <b>7/28/85</b>		22i. DEGREE <b>MD</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>July 29, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ferris Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>West Chester, Pennsylvania 19380</b>	
24. FUNERAL DIRECTOR <b>Joseph William Foster</b>		24b. ADDRESS <b>50 W. Broadway &amp; Williams St. Baltimore, Maryland 21014</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 31 1985</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>	

BP



219001

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 REG. NO. 2 0 2 3 0

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Baby girl LaQuita Monique (Bottoms) Gleason</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>7 19 1985</i>		2b. HOUR <i>4 32 A.M.</i>	
3. SEX <i>F</i>	4. RACE <i>Black</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>7 19 85</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <i>0 0 20</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford</i> MD.		
10. CITY OR TOWN OF DEATH <i>Harre de Grace</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Harford Memorial Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD.</i>		13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Edgewood</i>		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Brenda Bottoms</i>		16. SOCIAL SECURITY NO.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS <i>same as above</i>		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *Extreme prematurity*  
DUE TO, OR AS A CONSEQUENCE OF  
(b) *Cardio respiratory failure*  
DUE TO, OR AS A CONSEQUENCE OF  
(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Philip J. [Signature]</i>	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>2/19/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>	23b. DATE <i>8-3-85</i>	23c. NAME OF CEMETERY OR CREMATORY <i>St. James</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Harre de Grace Harford Md.</i>
24. FUNERAL DIRECTOR NAME ADDRESS <i>Arnold W. Beard 353 fountain St. HDG. Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>AUG 05 1985</i>	25b. REGISTRAR'S SIGNATURE <i>Leticia Davidson [Signature]</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

THE UNIVERSITY OF CHICAGO

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206031

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- STATE REGISTRAR		8-5 REG. NO. 20231							
1- DECEASED NAME (TYPE OR PRINT) Elfride F. Greenleaf				2a. DATE OF DEATH MONTH DAY YEAR 07 17 85		2b. HOUR 9 am			
3 SEX female		4 RACE white		5. DATE OF BIRTH MONTH DAY YEAR 05 27 04		6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.			
10 CITY OR TOWN OF DEATH Aberdeen		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 300 Stevens Circle, Apt. 2A				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b COUNTY Harford		13c CITY OR TOWN Aberdeen,		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Charles Davis				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Fornham					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. N/A		17 INFORMANT Chas. Boutin, 34 W. Bel Air Ave., Aberdeen, MD		17 ADDRESS 21001			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1-27-1983 to 7-17-1985, that (I) (we) lost saw the deceased alive on 7-1-1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE M.S. Sharaf El-Deane				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M.S. Sharaf El-Deane, M.D.				22e. ADDRESS P.O. Box 2104 Trimble Road Edgewood, MD. 21040					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 19, 1985		23c. NAME OF CEMETERY OR CREMATORY Angel Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Harford, MD			
24 FUNERAL DIRECTOR Tarring Funeral Home, PA, Aberdeen, MD, 21001-3399				25a. DATE REC'D. BY REGISTRAR JUL 23 1985		25b. REGISTRAR'S SIGNATURE J. W. Harrison			

BP

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(VRA 15, 4)

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159062

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 REG. NO. 20232

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JAMES Frank Gunther</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 8 1985</b>		2b. HOUR <b>6<sup>00</sup> PM</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 26, 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Edgewood, Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford</b> MD.	
10. CITY OR TOWN OF DEATH <b>Harre de Grace</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Harford Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Track Foreman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O RR</b>
13a. STATE <b>Md.</b>			13b. COUNTY <b>Harford</b>	13c. CITY OR TOWN <b>Street</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>John -- Gunther</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>unknown</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>705-09-7437</b>		17. INFORMANT ADDRESS <b>Street, Md. 21154</b> <b>Mrs. Franklin E. Gunther, 3310 Conowingo Road</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>As prior double heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary atherosclerosis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7-8</b>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) **Coronary atherosclerosis**

19a. DATE OF OPERATION <b>6-24-85</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Prostatectomy</b>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from **6-24-85** to **7-8-85**, that (I) (we) last saw the deceased alive on **7-8-85**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <b>Irvin H. Wachsmann</b>	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>7/9/85</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>IRVIN H. WACHSMANN</b>		22e. ADDRESS <b>Union Ave. Harre de Grace, Md. 21078</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>July 11, 1985</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Lutheran Cemetery, Joppa Harford</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Md.</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Howard K. McComas III, Abingdon, Md. 21009</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 10 1985</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in with funeral director's page should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 REG. NO. 2 0 2 3 3

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Frank J. Hartley</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>07 07 85</u>		2b. HOUR <u>438</u> M.
3. SEX <u>MALE</u>	4. RACE <u>WHITE</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>OCT. 24, 1914</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>70</u> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE STATE OR FOREIGN <u>WEST VIRGINIA</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Harford County</u> MD.	
10. CITY OR TOWN OF DEATH <u>Fallston</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Fallston General Hospital</u>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>FARM WORK</u>	
13a. STATE <u>MARYLAND</u>		13b. COUNTY <u>BALTIMORE</u>	13c. CITY OR TOWN <u>GLAN ARM</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <u>11839 HARFORD ROAD</u> 21057
14. FATHER'S NAME FIRST MIDDLE LAST <u>W. M. HARTLEY</u>		15. MOTHER'S NAME FIRST MIDDLE LAST <u>Lou ELLA HARTLEY</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>232201538</u>	17. INFORMANT <u>FAMILY RECORDS</u>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Intracranial Hemorrhage (CVA) involving left cerebral hemisphere</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Behinder state following CVA, Hypertensive Cardiovascular Disease</u>			
19a. DATE OF OPERATION <u>N/A</u>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>N/A</u>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) <u>N/A</u>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>N/A</u>	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>6/29</u> , 19 <u>85</u> , to <u>7/7</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>7/7</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Manuel M. Lazatin MD</u>	DEGREE <u>MD</u>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>7/11/85</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>LAZATIN, MANUEL</u>		22e. ADDRESS <u>1131 Bel Air Rd, Bel Air, MD 21014</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>CREMATION</u>	23b. DATE <u>JULY 9, 1985</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GREEN MOUNT</u>	23d. LOCATION CITY OR TOWN COUNTY STATE <u>BALTIMORE MARYLAND</u>
24. FUNERAL DIRECTOR NAME ADDRESS <u>EVANS CHARLOTTE MEMORIALS 8800 HARFORD ROAD</u>		25a. DATE REC'D. BY REGISTRAR <u>JUL 11 1985</u>	
		25b. REGISTRAR'S SIGNATURE <u>Jane W. Wilson</u>	



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 REG. NO. 2 0 2 3 4

1. DECEASED NAME (TYPE OR PRINT) <i>Audrey Gail Harris</i>		7a. DATE OF DEATH MONTH DAY YEAR <i>July 2 1985</i>		7b. HOUR <i>6<sup>05</sup> P M</i>	
3. SEX <i>Female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Nov. 26, 1934</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Chester, Pa.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>50</i> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 1 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH <i>Harford</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Harford Memorial Hospital</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford MD.</i>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>---</i>		13a. STREET ADDRESS / ZIP CODE <i>2005 Cherry Rd. 21040</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Edwin P. vanDeusen</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Audrey M. McFadden</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i> (IF YES, GIVE WAR OR DATES) <i>---</i>	
16b. SOCIAL SECURITY NO. <i>171-26-5314</i>		17. INFORMANT <i>John E. Harris, Jr., 2005 Cherry Road</i>		ADDRESS: <i>Edgewood, Md. 21040</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive pulmonary embolism</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>---</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>---</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>6-28 1985</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>6-28 1985</i> to <i>7-2 1985</i> that (I) (we) last saw the deceased alive on <i>7-2 1985</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Brian T. Yon M.D.</i>		DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>7/3/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>July 4, 1985</i>		23c. NAME OF CEMETERY OR CREMATORY <i>R.A. Ferris &amp; Co.</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>W. Chester Chester Pa.</i>		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>	
24. FUNERAL DIRECTOR NAME <i>Howard K. McComas III, Abingdon, Md. 21009</i>		25a. DATE REC'D. BY REGISTRAR			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical record must be kept on file and made available to the coroner.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 60M 7/84  
(VRA 15, 4)1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 5 20235  
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Lula Mae Hayes			2a DATE OF DEATH MONTH DAY YEAR 07 09 85		2b HOUR 12 58 AM
3 SEX Female	4 RACE Black	5 DATE OF BIRTH MONTH DAY YEAR 5 20 26		6 AGE (IN YEARS LAST BIRTHDAY) 59 YRS	7a IF UNDER 1 YEAR MONTHS DAYS 7b IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.	
10 CITY OR TOWN OF DEATH FALLSTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher		12b. KIND OF BUSINESS OR INDUSTRY Houston Board of Education
13a. STATE Texas		13b. CITY OR TOWN Houston	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE 2020 Wichita Houston, Tx. 77004	
14 FATHER'S NAME FIRST MIDDLE LAST Will Turman		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Gandy			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 418-34-9571		17 INFORMANT ADDRESS Ruby Davis 2020 Wichita Houston, Tx. 77004	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ac. CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE MI</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>HYPERTENSION</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>7/7/85</u> , 19 <u>85</u> , to <u>8/9</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>7/7</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>[Signature]</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Marilyn J S Hoxsey		22e ADDRESS Houston Gen Hospital			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 7-13-85		23c NAME OF CEMETERY OR CREMATORY Paradise North Cemetery	
23d LOCATION CITY OR TOWN COUNTY STATE Houston, Texas		23e DATE REC'D. BY REGISTRAR JUL 17 1985			
24 FUNERAL DIRECTOR E. F. NAME L. S. S. Funeral Home		25a DATE REC'D. BY REGISTRAR JUL 17 1985			
25b REGISTRAR'S SIGNATURE <u>[Signature]</u>		25c REGISTRAR'S NAME J. L. S. Registrar			

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) John Weldon Hayward					2a. DATE OF DEATH MONTH DAY YEAR JULY 1, 1985					2b. HOUR 7:10 A.M.	
1. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 3-10-1893		6. AGE (IN YEARS (LAST BIRTHDAY)) 92 YRS.		8. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County, MD.					
10. CITY OR TOWN OF DEATH Hayre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Citizen Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY --			
13a. STATE Maryland					13b. COUNTY Harford		13c. CITY OR TOWN Edgewood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Edward Hayward					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Kimmey						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. --		17. INFORMANT Regina McNamara, dghtr, same as above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ATHEROSCLEROTIC</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>HEART DISEASE</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. 11a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Dante Monacil</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7/1/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE MONACIL						22e. ADDRESS Hayre de Grace, Md 21078					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/3/85		23c. NAME OF CEMETERY OR CREMATORY Garden of Faith			23d. LOCATION CITY OR TOWN COUNTY STATE Balto, Md.			
24. FUNERAL DIRECTOR NAME SCHIMUNEK FUNERAL HOME, Balto, Md. 21236						25a. DATE REC'D. BY REGISTRAR JUL 09 1985			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 REG. NO. 20237

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Edith R Heppell</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>7 15 85</i>		2b. HOUR? <i>5:35 PM</i>	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR <i>MARCH 12, 1898</i>		
6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ENGLAND		10. CITIZEN OF WHAT COUNTRY? USA		11. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford</i> MD.		
12. CITY OR TOWN OF DEATH <i>Havre de Grace</i>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Citizen Nursing Home</i>		14. 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		
15. 12b. KIND OF BUSINESS OR INDUSTRY		16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		17. 13b. COUNTY <i>Harford</i>		
18. 13c. CITY OR TOWN HAVRE de GRACE		19. 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. 13e. STREET ADDRESS 505 CONGRESS AVE. 21078		
21. 14. FATHER'S NAME FIRST MIDDLE LAST MATTHEW MARLEY		22. 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET H.		23. 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		
24. 16b. SOCIAL SECURITY NO. 209 16 8780		25. 17. INFORMANT ADDRESS REV. BERNARD A. JENNINGS 114 N. UNION AVE. HdG, MD.		26. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive arteriosclerotic Cardio-vascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)		
27. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>1. Glaucoma in R eye. 2. old cerebrovascular accident.</i>						
28. 19a. DATE OF OPERATION		29. 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		30. 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
31. 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		32. 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		33. 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
34. 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		35. 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		36. 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
37. 21f. LOCATION STREET CITY OR TOWN COUNTY STATE		38. 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		39. 22b. SIGNATURE <i>SANG W. KIM</i>		
40. 22c. PHYSICIAN'S NAME (TYPE OR PRINT) SANG W. KIM		41. 22d. ADDRESS 308 S. Union Ave. Havre de Grace, MD 21078		42. 22e. DATE SIGNED July 15, 85		
43. 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		44. 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		45. 23b. DATE 17 JULY 85		
46. 23c. NAME OF CEMETERY OR CREMATORY SPESUTIE CEMETERY		47. 23d. LOCATION CITY OR TOWN COUNTY STATE PERRYMAN, HARFORD CO, MD.		48. 24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078		
49. 25a. DATE REC'D. BY REGISTRAR JUL 16 1985		50. 25b. REGISTRAR'S SIGNATURE <i>W. Harrison Handall</i>		51. 52. 53. 54. 55. 56. 57. 58. 59. 60.		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, this completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD., 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM P-13, RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 0 0 2 3 8

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		7 31 19 85		6:36 P.M.		
JAMES Allen HITCHCOCK								
3 SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.		IF UNDER 24 HRS.		
Male	White	Nov. 28, 1966	18 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland	U.S.A.			Harford County				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Fallston	Fallston General Hospital		Student					
13a. STATE	13b. CITY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS				
Maryland	Harford	Havre de Grace	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	3966 Wilkinson Rd., 21078				
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME							
Clarence Wilmer Hitchcock	Carolyn Louise Brewer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS						
NO	N/A	220-98-0216	C.W.Hitchcock, 3966 Wilkinson Rd., Havre de Grace, MD, 21078					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:								
8122 IMMEDIATE CAUSE (a) Thoraco-abdominal trauma								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								
(b) DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
		5:00 P.M. 7-31-19 85		Operator of motorcycle/auto collision.				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		21g. COUNTY		
		road		Rt. 755 @ Winters Run, Edgewood, Harford,		MD		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED				
		M.D. Assistant		8-1-85				
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS						
Ann M. Dixon, M.D.		111 Penn St., Balto., MD 21201						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial		Aug. 3, 1985		Angel Hill Cemetery		Havre de Grace, Harford, MD		
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3396		AUG 5 1985						

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DHMH - 17  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed, within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 G. NO. 20239

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Katherine Emma Hirschmann		2a. DATE OF DEATH MONTH DAY YEAR 7/19/85		2b. HOUR 7:00 pm	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 2 1892		6. AGE (IN YEARS LAST BIRTHDAY) 93	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.	
10. CITY OR TOWN OF DEATH Belair	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Belair Convalescent Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY -
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Lutherville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Christian Bau		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Marquardt			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No -		16b. SOCIAL SECURITY NO. 220-44-9371		17. INFORMANT ADDRESS Henry C. Hirschmann, 19 Wendslow Rd., 21093	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic cardiovascular dis.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>generalized arteriosclerosis</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>Hypertension</u> <u>atrial fibrillation</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOT BY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <u>May 28</u> , 19 <u>85</u> , to <u>June 19</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>July 17</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22a. SIGNATURE <u>BEN STEJZA</u>		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/19/85	
22b. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 846 SOUTH MAIN ST. Bel Air Md. 21014			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/22/85		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cem.	
23d. LOCATION (CITY OR TOWN) COUNTY STATE Timonium Balto. Md.					
24. FUNERAL DIRECTOR NAME Martin D. Lawson		ADDRESS 10 W. Padonia Rd. 21093		25a. DATE REC'D. BY REGISTRAR JUL 23 1985	
		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>			







BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 REG. NO. 2 0 2 4 0

1. DECEASED NAME (TYPE OR PRINT) <b>KATHLEEN (nmn) HORN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 4, 1985</b>			2b. HOUR <b>10:15<sup>A</sup></b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 5, 1923</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>61</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Bel Air</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>525 Robinson Street</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Harford</b>		13c. CITY OR TOWN <b>Bel Air</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Walter Harrison Smoot</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ila Marietta Burchette</b>			13e. STREET ADDRESS / ZIP CODE <b>525 Robinson Street 21014</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>---</b>		17. INFORMANT <b>Edward J. Horn, 525 Robinson St. Bel Air, Md.</b>		ADDRESS <b>21014</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of the breast</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Pneumonia, polio myelitis</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>1984</b> 19____ to <b>1985</b> 19____, that (I) (we) last saw the deceased alive on <b>6/10</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Arthur A. Scarpicchio MD</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>7-5-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Arthur A. Scarpicchio MD</b>				22e. ADDRESS <b>7620 York Rd Towson MD 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 8, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens, Bel Air Harford Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Howard K. McComas III, Abingdon, Md. 21009</b>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>JUL 8 1985 Julia Davidson-Randall</b>					

MEDICAL CERTIFICATION

20% COTTON FIBER

MADE IN U.S.A.



100% COTTON

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 0 2 4

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Paul		R.ichard		Hull				XX		7-3		19		85		a. 9:30	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	White	May 19, 1919		66 YRS.						7-3		19		85			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Virginia		U.S.A.				Harford County, MD.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Harve De Grace		45 Pine Street		Retired		US Govt.											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		Harford		Havre de Grace		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		45 Pine St./21078									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Hubert		Bertha															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
YES		WWII		235-05-3380		Richard E. Hull, 619 Law Street, Aberdeen, MD 21001											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																	
PART I DEATH WAS CAUSED BY																	
IMMEDIATE CAUSE (a) <u>Shotgun Wound of Chest</u>																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																	
(b) <u>subject shot himself</u>																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c) <u>subject shot himself</u>																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? (body only)													
				XX													
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
		est. HOUR A.M. MONTH DAY YEAR		subject shot himself													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION													
		Home		47 Pine St., Harve De Grace, Harford Co., Md.													
22a. I certify that I took charge of the remains described above, had an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
<i>Dennis F. Smyth</i>		M.D. Assistant		7-3-85													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Dennis F. Smyth, M.D.		111 Penn St., Balto., Md. 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION											
Removal/Burial		July 8, 1985		Monterey Cemetery		Monterey, Highland, Virginia											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399				JUL 10 1985		<i>John A. ...</i>											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND,  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 20242

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Harvey Franklin Ivins			2a. DATE OF DEATH MONTH DAY YEAR July 6 1985		2b. HOUR MIN. 6:46 A
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 1, 1912	6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.		
10. CITY OR TOWN OF DEATH Havre de Grace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TECH. EDITOR	12b. KIND OF BUSINESS OR INDUSTRY U.S. ARMY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Harford	13c. CITY OR TOWN Aberdeen	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Harry Oscar Ivins			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna Stevens		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-03-7318	17. INFORMANT ADDRESS Elizabeth Schantz, 44 Mount Royal Ave., Aberdeen, MD, 21001		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ventricular fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>7-1</u> , 19 <u>85</u> , to <u>7-5</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>7-5</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.					
22b. SIGNATURE M. S. SHARAF EL-DEANE		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. S. SHARAF EL-DEANE		22e. ADDRESS P. O. Box 935 Edgewood, Md 21040			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE JULY 9, 1985	23c. NAME OF CEMETERY OR CREMATORY GROVE PRESBYTERIAN	23d. LOCATION CITY OR TOWN COUNTY STATE ABERDEEN, HARFORD MARYLAND		
24. FUNERAL DIRECTOR NAME TERRACE FUNERAL HOME, P.A., ABERDEEN, MD. 21001-3399		25a. DATE REC'D. BY REGISTRAR JUL 10 1985	25b. REGISTRAR'S SIGNATURE John Davidson Anderson		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic death, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate from the deceased's file. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

BP



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214071

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 REG. NO. 20240

1. DECEASED NAME (TYPE OR PRINT) CHARLES JIRSA			2a. DATE OF DEATH MONTH DAY YEAR 7/22/85		2b. HOUR 4A <sup>M</sup>
3. SEX M	4. RACE CAUC	5. DATE OF BIRTH MONTH DAY YEAR 12 28 07	6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.		
10. CITY OR TOWN OF DEATH FAIRFAX	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FAIRFAX General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Balt. City Schools		12b. KIND OF BUSINESS OR INDUSTRY Education
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Md.		13b. COUNTY HA.	13c. CITY OR TOWN Whiteford	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1718 Deep Run Rd. 21160
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Jirsa		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 216 16 8299		17. INFORMANT ADDRESS Hazel E. Jirsa, 1718 Deep Run Rd., Whiteford Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>N.A.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>N.A.</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 minutes
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>N.A.</u>					
19a. DATE OF OPERATION 7-11-85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bladder cancer		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N.A.		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N.A. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) N.A.	
21d. INJURY OCCURRED WHERE <input checked="" type="checkbox"/> WHILE AT WORK <input type="checkbox"/> N.A.		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N.A.		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N.A.	
22a. I certify that (1) <u>this hospital</u> attended the deceased from <u>July 20, 1985</u> to <u>July 22, 1985</u> , that (1) <u>we</u> lost saw the deceased on <u>July 21, 1985</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above; (2) <u>we</u> view the body after death.					
22b. SIGNATURE H.W. Smith		DEGREE M.D.		22c. DATE SIGNED 7/22/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H.W. SMITH		22e. ADDRESS 715 Shawneck Rd 21014			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 24, 1985		23c. NAME OF CEMETERY OR CREMATORY Darlington	
23d. LOCATION CITY OR TOWN COUNTY STATE Darlington Harford Md					
24. FUNERAL DIRECTOR NAME John H. Harkins		ADDRESS 600 Main St., Delta, Pa., 17314		25a. DATE REC'D. BY REGISTRAR 7-28-1985	
		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rendell			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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207154

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 REC. NO. 20244

1. DECEASED NAME (TYPE OR PRINT) Lee Stump Johnson			2a. DATE OF DEATH MONTH DAY YEAR July 11 1985			2b. HOUR 3:45 A.M.				
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR July 30, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.				
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS) Harford Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE Md.			13b. COUNTY Harford		13c. CITY OR TOWN Jarrettsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1588 Jarrettsville Rd. 21084	
14. FATHER'S NAME FIRST MIDDLE LAST Howard Thompkins Stump Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Grace Smith							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-090077		17. INFORMANT ADDRESS Donald L. Johnson same as above					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio - Pulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Coronary Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Congestive Heart Failure - Ascites &amp; Edema</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>7-8</u> 19 <u>85</u> , to <u>7-11</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>7-11</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) see the body after death.										
22b. SIGNATURE <u>Charles J. Foley Jr. M.D.</u>						22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>CHARLES J. FOLEY JR. M.D.</u>		
22e. ADDRESS						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 7/12/1985		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Balto. Md.			
24. FUNERAL DIRECTOR NAME ADDRESS M. Gladden Kurtz Jarrettsville, Md.						25a. DATE REC'D. BY REGISTRAR JUL 18 1985		25b. REGISTRAR'S SIGNATURE <u>John A. ...</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 NO. 20245

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MARIE P. KEARNEY			2a. DATE OF DEATH MONTH DAY YEAR 07 19 85			2b. HOUR 19 A			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 3 18 96		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 23 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Fallston, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.			
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Veterans Adm.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD		13b. COUNTY Harford		13c. CITY OR TOWN Fallston		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2436 Friendship Rd. 21047	
14. FATHER'S NAME FIRST MIDDLE LAST Frank A. Kearney					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma B. Smith				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-34-1664		17. INFORMANT ADDRESS 2436 Friendship Rd. Miss Dorothy M. Kearney, Fallston, Md. 21047					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Met. Adenoc Carcinoma of Colon Infiltrative  
DUE TO, OR AS A CONSEQUENCE OF b) Lymphatic Spread  
and c) Septic Shock  
DUE TO, OR AS A CONSEQUENCE OF ASCVD & Chr. Atrial Fibrillation.

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from March 19 84 to July 19 84, that (I) (we) last saw the deceased alive on 7-19-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Muriel Mathur						22c. DATE SIGNED 7-19-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MURIEL MATHUR						22e. ADDRESS 1305 Fallston Rd, Fallston Md 21047	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-22-1985		23c. NAME OF CEMETERY OR CREMATORY St. John R. Cath. Ch. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Long Green Harto. Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Lessaun F. H. 17159 Belair Rd						25a. DATE REC'D BY REGISTRAR JUL 22 1985	
25b. REGISTRAR'S SIGNATURE [Signature]							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or either traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. The medical examiner must be notified of a death. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of a death.

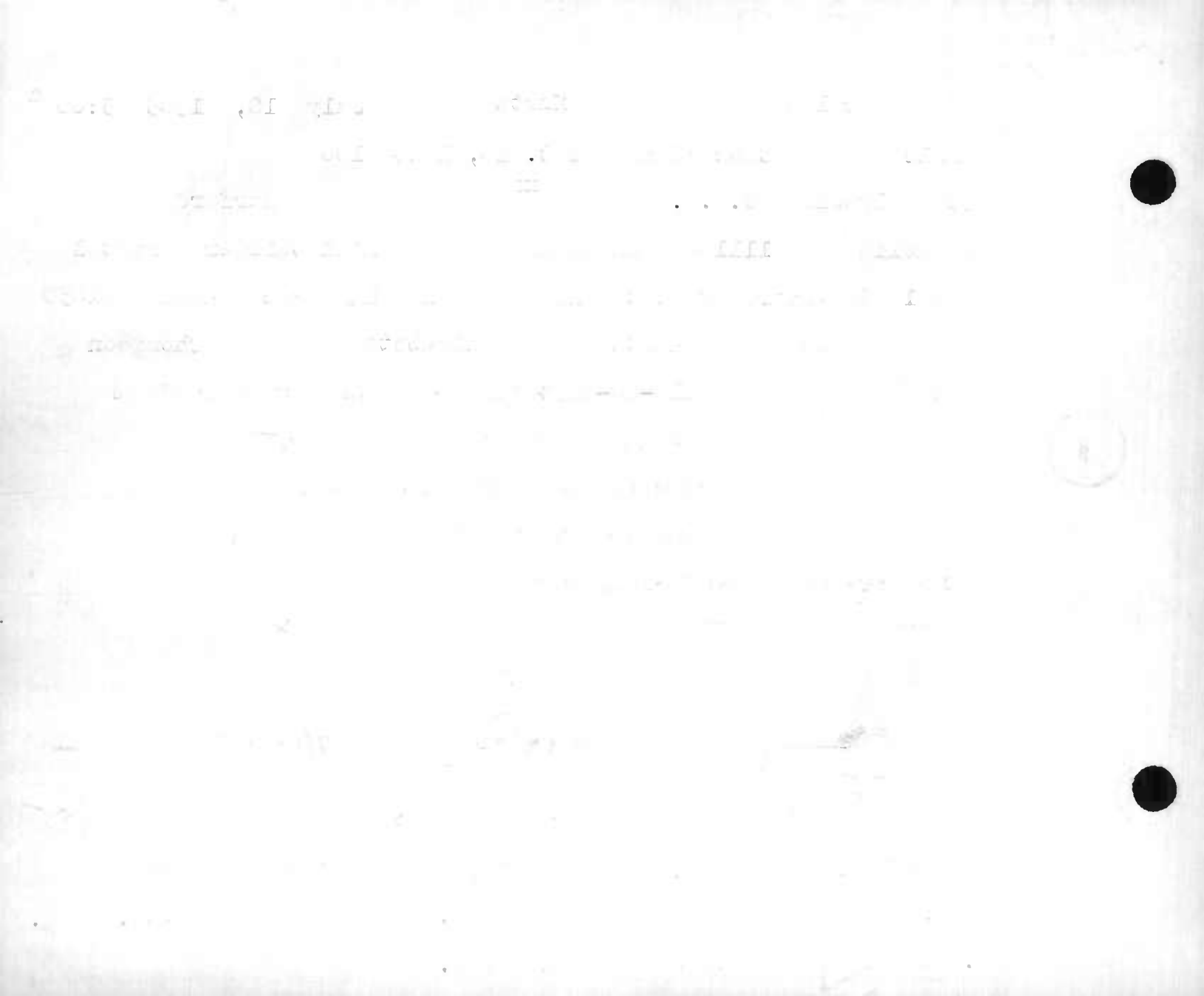
210111

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 20246

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Ralph Kurtz</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 18, 1985</b>		2b. HOUR AM PM <b>5:00 A</b>
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 10, 1884</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>100</b> YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford</b> MD.	
10. CITY OR TOWN OF DEATH <b>Magnolia</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1111 Hanson Road</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mail Carrier</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Postal</b>
13a. STATE <b>Maryland</b>			13b. CITY OR TOWN <b>Harford</b>	13c. CITY OR TOWN <b>Forest Hill</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Adam Ebaugh Kurtz</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Thompson</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-28-6854</b>		17. INFORMANT ADDRESS <b>Glenna Kurtz same as above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CANCER OF LUNG, PRIMARY</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CANCER OF PROSTATE, PRIMARY</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>ISCHEMIC HEART DISEASE</b>					
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>— P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>—</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>—</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>—</b>	
22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>6/18/84</b> 19 <b>—</b> to <b>7/18/85</b> 19 <b>—</b> , that (I) <del>(was)</del> lost saw the deceased alive on <b>6/15/85</b> 19 <b>—</b> , and that in (my) <del>(my)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(did)</del> (did not) view the body after death.					
22b. SIGNATURE <b>David R. Padrino</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>7/18/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAVID R. PADRINO, M.D.</b>		22e. ADDRESS <b>57 E. BROADWAY BEL AIR, MD 21014</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>7/19/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Mem. Park</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Balto. Md.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>M. Gladden Kurtz III Jarrettsville, Md.</b>			
25a. DATE REC'D. BY REGISTRAR <b>JUL 23 1985</b>		25b. REGISTRAR'S SIGNATURE <b>J. J. J.</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates to pages 1 and 2 and file with the funeral director. Page 1 and 2 should be filed with the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) <b>SUSIE TYLER LANG</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>7 12 85</b>		2b. HOUR <b>3:00</b> M					
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 11, 1902</b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Sulinda, Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.					
10. CITY OR TOWN OF DEATH <b>FALLSTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FALLSTON, GENECA</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HARFORD</b> MD.					
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Seamstress</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Upholstery</b>							
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Maryland</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Pasadena</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>James -- Wood</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>-- Unknown -- Walton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>217-05-7550</b>		17. INFORMANT ADDRESS <b>William T. McCleary, 500 Trimble Road Joppatowne, Md. 21085</b>					
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diabetes + Mild Cerebral Paresis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Systolic Shock</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Cachexia, Alzheimer's Disease, Extensive Decubiti</b>									
19a. DATE OF OPERATION <b>7/6/85</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ext. Decubiti</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>N/A</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>N/A</b>		21f. LOCATION CITY OR TOWN COUNTY STATE <b>N/A</b>					
22a. I certify that (this hospital) attended the deceased from <b>7/1/85</b> , 19 <b>85</b> , to <b>7/12</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>7/12</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Mamul M. Lazatin</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>7/12/85</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LAZATIN, Mamul</b>		22e. ADDRESS <b>1131 Bel Air Rd, Bel Air, MD 21014</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 15, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Park</b>					
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie A.A. Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 16 1985</b>							
24. FUNERAL DIRECTOR NAME <b>Howard K. McComas III</b>		ADDRESS <b>Abingdon, Md. 21009</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

203218

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 REG. NO. 20247

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 20248			
1. DECEASED NAME [TYPE OR PRINT] FIRST MARY MIDDLE C. LAST LEARY				2a. DATE OF DEATH MONTH 7 DAY 28 YEAR 1985 2b. HOUR 7:30p			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH Jan DAY 6, YEAR 1908 <sup>AR</sup>		6. AGE [IN YEARS LAST BIRTHDAY] 77 YRS	
7a. BIRTHPLACE [STATE OR FOREIGN COUNTRY] Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.	
10. CITY OR TOWN OF DEATH HAVRE DE GRACE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITIZENS NURSING HOME		12a. USUAL OCCUPATION [TYPE OF WORK OR MOST OF WORKING LIFE] Telephone Oper.		12b. KIND OF BUSINESS OR INDUSTRY Brooklyn, N.Y.	
13a. STATE Maryland		13b. CITY OR TOWN Cecil		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS 135 Doctor Jack Road	
14. FATHER'S NAME FIRST John MIDDLE R. LAST Linton		15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE D. LAST Dougherty		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] No			
16b. SOCIAL SECURITY NO. 078-20-7135		17. INFORMANT Daniel D. Leary, 135 Dr. Jack Rd., Port Deposit, Md.		18. ADDRESS			
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Old CVA DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
20a. DATE OF OPERATION		20b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN STREET COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/8/80 to 7/28/85, that (I) (we) lost saw the deceased alive on 7/28/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John D. Yun				DEGREE		22c. DATE SIGNED 7/28/85	
22d. PHYSICIAN'S NAME [TYPE OR PRINT] John D. Yun				22e. ADDRESS Samuel Grace, Md.		22f. DATE RECEIVED BY REGISTRAR 7/28/85	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 1, 1985		23c. NAME OF CEMETERY OR CREMATORY St. Marks Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Perryville, Cecil, Maryland	
23e. FUNERAL HOME Lee H. Patterson & Son, Perryville, Maryland.				23f. REGISTRAR'S SIGNATURE			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR items 13c, 13e  
STATE film# G605-7/18/85  
REGISTRAR jlb

85 REG. NO. 20249

1. DECEASED NAME (TYPE OR PRINT) RICHARD WALLACE LESSIG, SR			2a. DATE OF DEATH MONTH DAY YEAR 7 3 85			2b. HOUR A M 4-05				
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 8/11/19		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.				
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Innison Carp. Local 101		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Balto.		13c. Perry Hall Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3815 Schroeder Ave. 21236	
14. FATHER'S NAME FIRST MIDDLE LAST Irwin Lessig				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Verda Lloyd Reigner						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WW II 212-01-3806		17. INFORMANT ADDRESS Virginia L. Lessig, same address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe COPD due to Emphysema. DUE TO, OR AS A CONSEQUENCE OF (b) Periph. Arterial Enusyst. DUE TO, OR AS A CONSEQUENCE OF (c) Cardiac arryth - arial fib. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1983, 19, to 7-3 1985, that (I) (we) lost saw the deceased alive on 7-2 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE B. D. PAREKH MD.					DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7-3-85.		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS 1908 HARFORD RD, FALLSTON, MD 21047					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/6/85		23c. NAME OF CEMETERY OR CREMATORY Holly Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.			
24. FUNERAL DIRECTOR Schmunek Funeral Home, Inc. 9705 Belair Road, Balto., Md. 21236						25a. DATE REC'D. BY REGISTRAR JUL 09 1985		25b. REGISTRAR'S SIGNATURE A. J. ...		

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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210038

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8 5 2 0 2 5 0

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William H. Lyall		2a. DATE OF DEATH MONTH DAY YEAR July 13 1985		2b. HOUR 5:55 P	
3 SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 4 1909		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Repairman		12b. KIND OF BUSINESS OR INDUSTRY Railroad	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Darlington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Roma Lyall		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Bare		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 218-05-4685		17. INFORMANT ADDRESS Darlington, MD Pearl L. Lyall 4136 Flintville Road					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Klebsiella pneumoniae</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pseudomonas sepsis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>7/19</u> 19 <u>85</u> to <u>7/13</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>7/13</u> 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Louis Silverstein</u>				DEGREE <u>MD</u>		22c. DATE SIGNED <u>7/13/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>LOUIS SILVERSTEIN</u>				22e. ADDRESS <u>P.O. Box 8, 2033. WASHINGTON ST, HAVRE DE GRACE, MD 21078</u>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/16/85		23c. NAME OF CEMETERY OR CREMATORY Conowingo Baptist		23d. LOCATION CITY OR TOWN COUNTY STATE Conowingo Cecil MD	
24. FUNERAL DIRECTOR NAME ADDRESS John H. Harkins 600 Main Street Delta, PA				25a. DATE REC'D. BY REGISTRAR JUL 22 1985		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Rodgers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page.]*

205065

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corpse papers. Page 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

20251

1. DECEASED NAME (TYPE OR PRINT) MARGUERITE Amoss Maddox			2a. DATE OF DEATH MONTH DAY YEAR 7 15 85		2b. HOUR 3:22 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan 06 1895		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.		10. CITY OR TOWN OF DEATH HAVRE de GRACE			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITIZENS NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Harford	13c. CITY OR TOWN Falston	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Scarff		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Georgia Amoss			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 381-09-5698		17. INFORMANT ADDRESS Rosser Wade Maddox 321 Westshire Rd. 21229	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>old age</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>AS CUP</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebrovascular insufficiency</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (d)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> 19 <u>79</u> to <u>July</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>July</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>John D. Yun</u>		DEGREE		22c. DATE SIGNED 7-15-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John D. Yun		22e. ADDRESS 319 S. Union Ave. Havre de Grace, Md		22f. LOCATION Baltimore 21078 COUNTY Maryland	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 18, 1985		23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat'l Cem.	
23d. LOCATION Baltimore		23e. COUNTY Maryland		23f. STATE Maryland	
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Avenue		24b. ADDRESS 21229		25a. DATE RECEIVED BY REGISTRAR JUL 19 1985	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE			

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100 200 300 400 500 600 700 800 900 1000

UNITED STATES DEPARTMENT OF THE INTERIOR



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UNITED STATES DEPARTMENT OF THE INTERIOR



190146

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 REG. NO. 2 0 2 5 2

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>George FRANCIS Martin, SR.</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>7 7 85</b>		2b. HOUR <b>4 40 P M</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 6, 1913</b>	
6. AGE (IN YEARS (LAST BIRTHDAY)) <b>72</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 1 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Rushville, N.Y.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford Co.</b> MD.	
10. CITY OR TOWN OF DEATH <b>Fallston</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Fallston General Hos.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mechanic</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Garage</b>		13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13b. STREET ADDRESS / ZIP CODE <b>108 Fern Drive 21085</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Phillip -- Martin</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine -- Harrington</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes WWII</b>	
16b. SOCIAL SECURITY NO. <b>143-03-0126</b>		17. INFORMANT <b>Mrs. Helen Kettlebar</b>		ADDRESS <b>21085 108 Fern Drive, Joppa, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary Artery Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>12 hrs</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>a</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (1) (this hospital) attended the deceased from <b>7 July 19 85</b> to <b>7 July 19 85</b> , that (2) (we) last saw the deceased alive on <b>7 July 19 85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (2) (we) (did) (did not) view the body after death.		22b. SIGNATURE DEGREE <b>Harmon</b> <b>MD</b>	
22c. DATE SIGNED <b>7 July 85</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Harmon</b>		22e. ADDRESS <b>FGH</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 10, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bel Air Harford Md.</b>		24. FUNERAL DIRECTOR NAME <b>Howard K. McComas III</b>		25a. DATE REC'D BY REGISTRAR <b>JUL 09 1985</b>	
25b. REGISTRAR'S SIGNATURE <b>John Harrison</b>		25c. ADDRESS <b>Abingdon, Md. 21009</b>		25d. ZIP CODE <b>21009</b>	

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211002

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/77

FOR  
STATE  
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 0 2 5 3

1. DECEASED NAME (TYPE OR PRINT) <b>RICHARD Wm. MCARTOR</b>		7a. DATE KNOWN OF DEATH ESTIMATED <b>7-24-1985</b>		7b. HOUR <b>9:25 PM</b>
2. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH <b>4</b> DAY <b>6</b> YEAR <b>40</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>45</b> YRS.	IF UNDER 1 YR MONTHS <b>0</b> DAYS <b>0</b>
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>HARFORD</b> MD
10. CITY OR TOWN OF DEATH <b>FALLSTON</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FALLSTON GENERAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Office Manager</b>
12b. KIND OF BUSINESS OR INDUSTRY <b>Ins. Finance</b>		13a. STATE <b>MD</b>		
13b. COUNTY <b>HARFORD</b>		13c. CITY OR TOWN <b>MONKTON</b>		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2400 CHARLTON RD.</b>		
14. FATHER'S NAME FIRST <b>Donald</b> MIDDLE <b>Jr.</b> LAST <b>McArto</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Grace</b> MIDDLE <b>M.</b> LAST <b>Penn</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>214-36-8068</b>		
16c. INFORMANT <b>Hospital Record</b>		ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. <b>ASUVD</b> (b) <b>ASUVD</b> DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE <b>Luis E Renjel</b>		TITLE (SPECIFY) <b>M.D. Deputy</b>		DATE SIGNED <b>7-25-85</b>
EXAMINER'S NAME (TYPE OR PRINT) <b>LUIS E RENJEL</b>		ADDRESS <b>464 QLIAMME ST HANOVER</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>7-27-85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Jarrettsville</b>	23d. LOCATION CITY OR TOWN <b>Jarrettsville</b>	COUNTY <b>Balto. Co.</b>
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc.</b>		ADDRESS <b>5305 Harford Road</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 26 1985</b>
		25b. REGISTRAR'S SIGNATURE <b>J. Ruck</b>		

5232

212014

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 2 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE REPRODUCED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 0254	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HUBERT DENNY McCLURE</b>										2a. DATE OF DEATH KNOWN <input type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <b>7 19 1985</b>	
3. SEX <b>M</b>	4. RACE <b>C</b>	5. DATE OF BIRTH (LAST BIRTHDAY) MONTH DAY YEAR <b>1 12 29 57</b> YRS.		6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS <b>27</b> YRS.	IF UNDER 1 YR. MONTHS DAYS <b>0 0 0</b>	IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>7 19 1985</b>		2d. HOUR <b>3:31</b> A		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W. VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HARFORD</b> MD.					
10. CITY OR TOWN OF DEATH <b>FALLSTON</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FALLSTON GENERAL HOSP.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Government</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Federal</b>			
13a. STATE <b>Pa</b>		13b. COUNTY <b>NORFOLK</b>		13c. CITY OR TOWN <b>Delta</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>RT 1- Box 241</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Blaine McClure</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Myrtle Roberts</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes Korean War</b>				16b. SOCIAL SECURITY NO. <b>178-22-7620</b>		17. INFORMANT ADDRESS <b>Hospital Port</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) <b>ASCUD.</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Luis E. Remy</b>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>7-19-85</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Luis E Remy</b>				ADDRESS <b>464 Alliance St Harford</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/22/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Stewartstown Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Stewartstown, York, Penna.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>K. W. Osburn Fitt., Stewartstown, Pa.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 25 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

999999

DMH: 17  
(VR A15 ME (5))  
15M 7/77

1052

191053

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 85 20255

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>SARA L MEARS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 4<sup>TH</sup> 1985</b>		2b. HOUR MIN. <b>5<sup>57</sup> A<sup>M</sup></b>		
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 26 1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>74 YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>DELAWARE</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford</b> MD.	
10. CITY OR TOWN OF DEATH <b>Harford</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Harford Mem. Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>REGISTERED NURSE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY <b>MD. Cecil</b>				13b. CITY OR TOWN <b>Rising Sun</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE FRANK MYNICH</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>IDA LOUISE SMITH</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>219-34-0942</b>		17. INFORMANT ADDRESS <b>RALPH K MEARS (SAME AS 13)</b>			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

**Myocardial Infarction**

DUE TO, OR AS A CONSEQUENCE OF

(b)

**Coronary Thrombosis**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **diabetes mellitus**

## MEDICAL CERTIFICATION

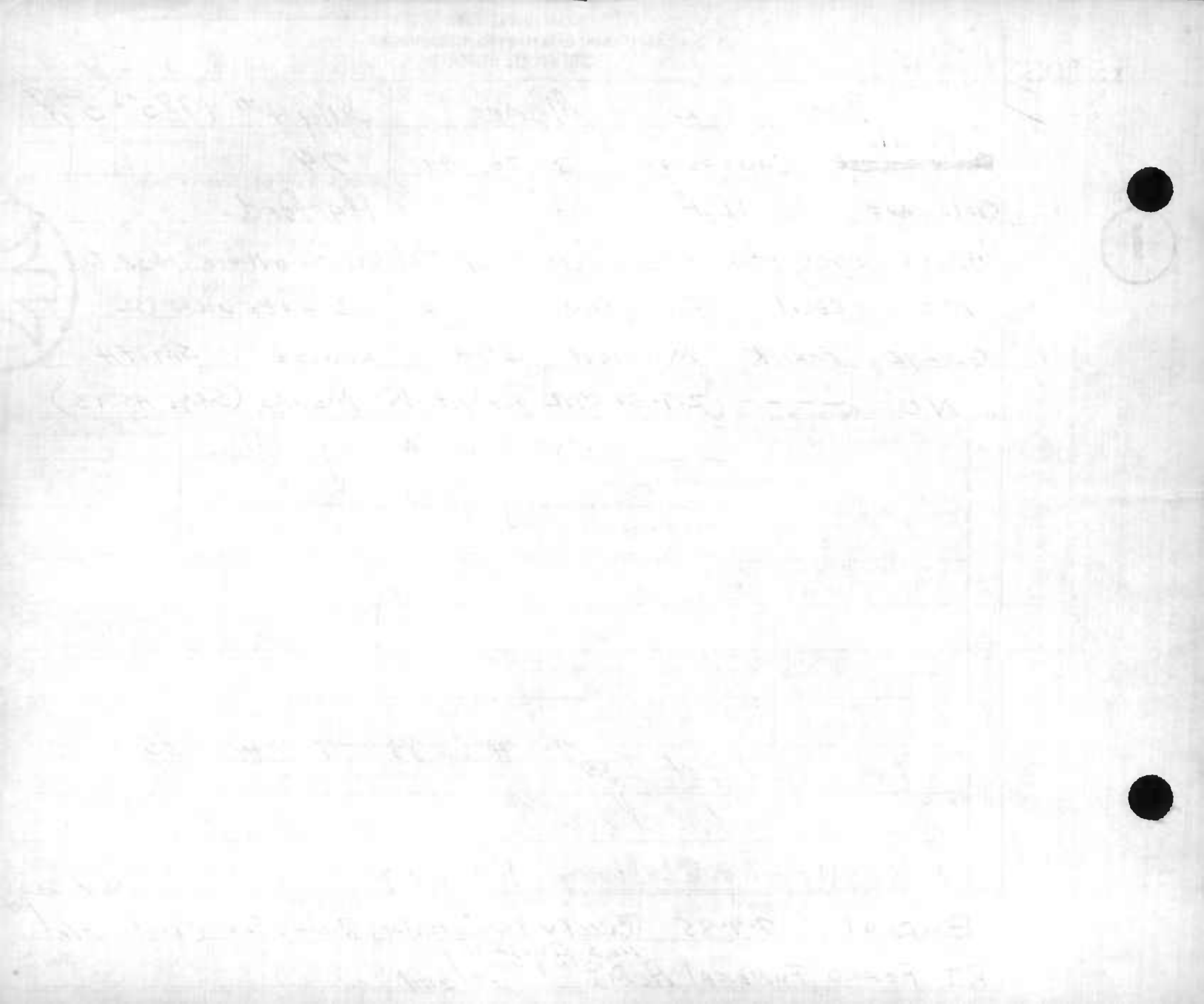
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7-4 1985</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>7-4 1985</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>7-4 1985</b> to <b>7-4 1985</b> , that (I) (we) last saw the deceased alive on <b>7-4 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE OF DECEASEE <b>M. S. SHARAF EL-DEANE</b>						22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. S. SHARAF EL-DEANE</b>						22e. ADDRESS <b>RO. BOX 935 EDGEWOOD MD 21040</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>7-9-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BROOKVIEW CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rising Sun Cecil MD</b>	
24. FUNERAL DIRECTOR NAME <b>RT FOARD FUNERAL HOME</b>				25a. DATE REC'D. BY REGISTRAR <b>8 1985</b>		25b. REGISTRAR'S SIGNATURE <b>J. H. W. W. W.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must call the medical examiner.





203440

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 NO. 20250

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARGARET MARY MELENDEZ</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7 14 85</b>		2b. HOUR <b>7 PM</b>
1. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>09 10 07</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Brooklyn, New York</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HARFORD COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>TALLSTON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FAULSTON GEN HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Child Care Center</b>
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Harford</b>	13c. CITY OR TOWN <b>Joppa</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Joseph Knight</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Dorothy M. Grehle</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>218-40-0222</b>		17. INFORMANT ADDRESS <b>Mrs. Doris A. Gebbia, Lombard, Ill. 60148 2S205 Valley Road</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Strongly suspect Acute Myocardial</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Infarct or Acute Pulmonary Embolism</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.1a <b>Cornary Artery Disease, Atherosclerotic Cardiovascular Disease, Severe</b>					
19a. DATE OF OPERATION <b>7/14/85</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N/A</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>N/A</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>N/A</b>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.) <b>N/A</b>	21f. LOCATION (STREET CITY OR TOWN COUNTY STATE) <b>N/A</b>		
22a. I certify that (I) (this hospital) attended the deceased from <b>7/14/85</b> 19 <b>85</b> to <b>7/14</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>7/14/85</b> 19 <b>85</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Manuel M Lazatin</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>7/14/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LAZATIN, MANUEL</b>		22e. ADDRESS <b>1131 Bel Air Rd, Bel Air Md 21014</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>July 18, 1985</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Post Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Edgewood Arsenal Harford Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Howard K. McComas III, Abingdon, Md. 21009</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 16 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Davidson</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial-transit permit. Then please remove completed Pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 REG. NO. 20257

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) HERMAN J METZGER			2a. DATE OF DEATH MONTH DAY YEAR JULY 1, 1985		2b. HOUR M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR OCT 22 1908	6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD County MD.		
10. CITY OR TOWN OF DEATH EDGEWOOD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1828 JOHN DR.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BETH-STEEL		12b. KIND OF BUSINESS OR INDUSTRY RETIRED
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.			13b. COUNTY HARFORD	13c. CITY OR TOWN EDGEWOOD	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST UNK			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-07-8818		17. INFORMANT ADDRESS No TRAL METZGER SAME	
18. CAUSE OF DEATH (Enter only one cause per line for a), b), and c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Met. Epithelial Carcinoma c</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Marine Asbestis</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8-3-19</u> 19 <u>85</u> to <u>7-1</u> 19 <u>85</u> that (I) (we) last saw the deceased on <u>6/21</u> 19 <u>85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) sew the body after death.					
22b. SIGNATURE Murli N. Mathur		DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-3-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Murli N. Mathur, M.D.		22e. ADDRESS 1305 Fallston Rd. Fallston, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JULY 3, 1985	23c. NAME OF CEMETERY OR CREMATORY OAKLAND		23d. LOCATION CITY OR TOWN COUNTY STATE EASTWARD BALTO. MD.
24. FUNERAL DIRECTOR NAME CONNELLY FUNERAL HOME		ADDRESS 300 MACE AVE		25a. DATE REC'D. BY REGISTRAR JUL 12 1985	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

MEDICAL CERTIFICATION

CS-2-F



206057

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8560 20258

1 - FOR STATE REGISTRAR		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
Lou NMN Miller		July 19, 1985		11:55 AM	
3 SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR IF UNDER 72 HRS	
FEMALE	ORIENTAL	JANUARY 15, 1909	76 YRS	MONTHS DAYS	HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH		
RUSSIA	USA		Harford MD.		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b KIND OF BUSINESS OR INDUSTRY	
Havre de Grace	Harford Memorial Hosp.		HOMEMAKER		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE	
MD	HA	Havre de Grace		100 Revolution St. Apts. 401 21078	
14 FATHER'S NAME FIRST MIDDLE LAST	15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		
YOSHIMATSU	YAMAZAKI		16b SOCIAL SECURITY NO		
	SHIGE		213 36 9643		
17 INFORMANT ADDRESS			MRS. TAE MORGAN 416 BATTERY DRIVE, HAVRE de GRACE, MD.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Ca of lung metastasis					
AS STB.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
J. Lee		M.D.		7/22/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
J. Lee		Union Med. Clin. c. Havre de Grace			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
BURIAL	22JULY85	HARFORD MEMORIAL GARDENS	ALDINO, HARFORD CO, MARYLAND		
24 FUNERAL DIRECTOR NAME ADDRESS			25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078			JUL 22 1985	C. Davidson-Randall	

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FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 REG. NO. 20259

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>PAULINE — MILLER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 20, 1985</b>		2b. HOUR A. <b>12:57</b> M.		
3. SEX <b>FEMALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>January 20, 1903</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>82</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Bel Air</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bel Air Nursing &amp; Convalescent Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Homemaker</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Harford Co.</b>		13c. CITY OR TOWN <b>Bel Air</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <b>1419 MacPhail Road 21014</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>ALEX — Woody</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Cora — Long</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>240-42-0418-D</b>		17. INFORMANT (DAUGHTER) 879-4646 <b>Mrs. Lucille M. King</b>		ADDRESS <b>1419 MacPhail Road Bel Air, Maryland 21014</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>PARKINSON'S DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>DEMENTIA</b>							
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) ( <del>we</del> ) attended the deceased from <b>1/2/85</b> , 19____, to <b>7/20/85</b> , 19____, that (I) ( <del>we</del> ) last saw the deceased alive on <b>6/27/85</b> , 19____, and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.							
22b. SIGNATURE <b>David R. Padrino</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>July 20, 1985</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>David R. Padrino, M.D.</b>				22e. ADDRESS <b>57 East Broadway, Bel Air, Maryland 21014</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 22, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadow Fork Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Laurel Springs, Allegheny Co., North Carolina</b>	
24. FUNERAL DIRECTOR <b>Joseph William Foster</b>		50 W. Broadway & Williams St. Bel Air, Maryland 21014		25a. DATE REC'D. BY REGISTRAR <b>JUL 23 1985</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson</b>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified if not already notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR											
I. DECEASED NAME (TYPE OR PRINT)					7a. DATE OF DEATH		MONTH		DAY	YEAR	2b. HOUR
NEPTIE S. MOORE					7		23		85	11:50aM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		August 7 1900		84		MONTHS		DAYS	
7a. BIRTHPLACE		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		United States		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		HARFORD MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY			
HAVRE de GRACE		CITIZENS NURSING HOME				Homemaker		Own Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2630 Dublin Road/21154			
Maryland		Harford		Street							
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
G. Nelson Whiteford					Louisa Barton						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No					218-32-5136		J. Arthur Moore 2630 Dublin Road Street, MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>											
DUE TO, OR AS A CONSEQUENCE OF <u>Chronic Heart Disease</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF <u>Anti-Bordet's</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Carcinoma of Colon</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED						
			HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED			21e. PLACE OF INJURY		21f. LOCATION						
WHILE <input type="checkbox"/> AT WORK			[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>7/21</u> , 19 <u>85</u> , to <u>7/23</u> , 19 <u>85</u> , that (I) (we) lost											
saw the deceased alive on <u>7/21</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. PHYSICIAN'S NAME					DEGREE			22c. DATE SIGNED			
DANTE MONAKIL					ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/>			7/23/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS						
					672 S. Union Ave Harford, Md						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION				
Burial			7/26/85		Wm. Walters Mem. Cem.		Jarrettsville Harford MD				
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR						
NAME					25b. REGISTRAR'S SIGNATURE						
John Harkins 600 Main Street Delta, PA 17314					JUL 26 1985 Julia Davidson-Hendall						

BP



213021

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 REC'D. 20261

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Martha c. Morrissey</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7 27 85</b>		2b. HOUR AM PM <b>10 35 AM</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 14 15</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford</b> MD.	
10. CITY OR TOWN OF DEATH <b>Fallston</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Fallston General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Lansdown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>- Williams</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Louise Wolf</b>		16. ADDRESS <b>Mr. John E. Andrews 613 Foxcroft Dr. Bel Air Md. 21014</b>			
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>		18. SOCIAL SECURITY NO. <b>215 01 2124</b>		19. INFORMANT <b>Mr. John E. Andrews 613 Foxcroft Dr. Bel Air</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>pulmonary emboli c) hypertension</b>		<b>2 days</b>	
DUE TO, OR AS A CONSEQUENCE OF (c) <b>terminal Hepatic Ca.</b>		<b>a few months.</b>	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

19a. DATE OF OPERATION <b>7/27/85</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>rt. hip fracture</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR MONTH DAY YEAR <b>P.M. 7 22 1985</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>fall</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>1613 Foxcroft Dr. Bel Air Harford Md.</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>7/20</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE <b>Jim Hong Rhee</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>7/27/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jim Hong Rhee</b>				22e. ADDRESS <b>1800 Harford Rd. Fallston, Md.</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 29, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Baltimore, Maryland</b>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>JUL 29 1985 [Signature]</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be retained by the funeral director. It should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1900

Mr. John. Andrews & Co. Inc. 101 Air  
Mott St. N.Y.C.

Insurance Co. Inc. 101 Air  
Mott St. N.Y.C.

205032

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 REG. NO. 20262

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM EARL MUNCHEY		2a. DATE OF DEATH MONTH DAY YEAR 7 11 85		2b. HOUR 7:05 PM	
3. SEX Male		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 11 17 15 69		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
10. CITY OR TOWN OF DEATH FAIRFAX		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FAIRFAX GENERAL HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MECHANIC		12b. KIND OF BUSINESS OR INDUSTRY MOTORCAR	
13a. STATE PA		13b. COUNTY DELTA		13c. CITY OR TOWN DELTA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ELIJAH L. MUNCHEY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EVA RADCLIFF		16. STREET ADDRESS / ZIP CODE RD 3 BOX 199 17314			
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WW2		18. SOCIAL SECURITY NO. 236-16-2079		19. INFORMANT ADDRESS BEULAH E. MUNCHEY, R.D.3, DELTA, PA.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SCAPHOMUS CELL CARCINOMA 1 YEAR</u> <u>OF THE HEAD + NECK</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>RIGHT MIDDLE LOBE PNEUMONIA</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <u>7/3</u> , 19 <u>85</u> , to <u>7/11</u> , 19 <u>85</u> , that (I) (we) lost <u>saw</u> the deceased alive on <u>7/11</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) sign the body after death.							
23. SIGNATURE John P. Edwards, M.D.		23a. PHYSICIAN'S NAME (TYPE OR PRINT)		23b. ADDRESS Rm 409 FAIRFAX GENERAL HOSP 200 MILTON AVE - FAIRFAX		23c. DATE SIGNED 7/11/85	
23d. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23e. DATE JULY 15, 1985		23f. NAME OF CEMETERY OR CREMATORY LAKE VIEW MEM. PARK		23g. LOCATION CITY OR TOWN COUNTY STATE SYKESVILLE CARROLL MARYLAND	
24. FUNERAL DIRECTOR NAME JOHN H. HARKINS, 600 MAIN STREET, DELTA, PA				25. DATE REC'D. BY REGISTRAR JUL 17 1985			
26. REGISTRAR'S SIGNATURE John H. Harkins				27. REGISTRAR'S SIGNATURE John H. Harkins			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an autopsy required.



210117

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and at any event, within 72 hours after death.

# STATE OF MARYLAND

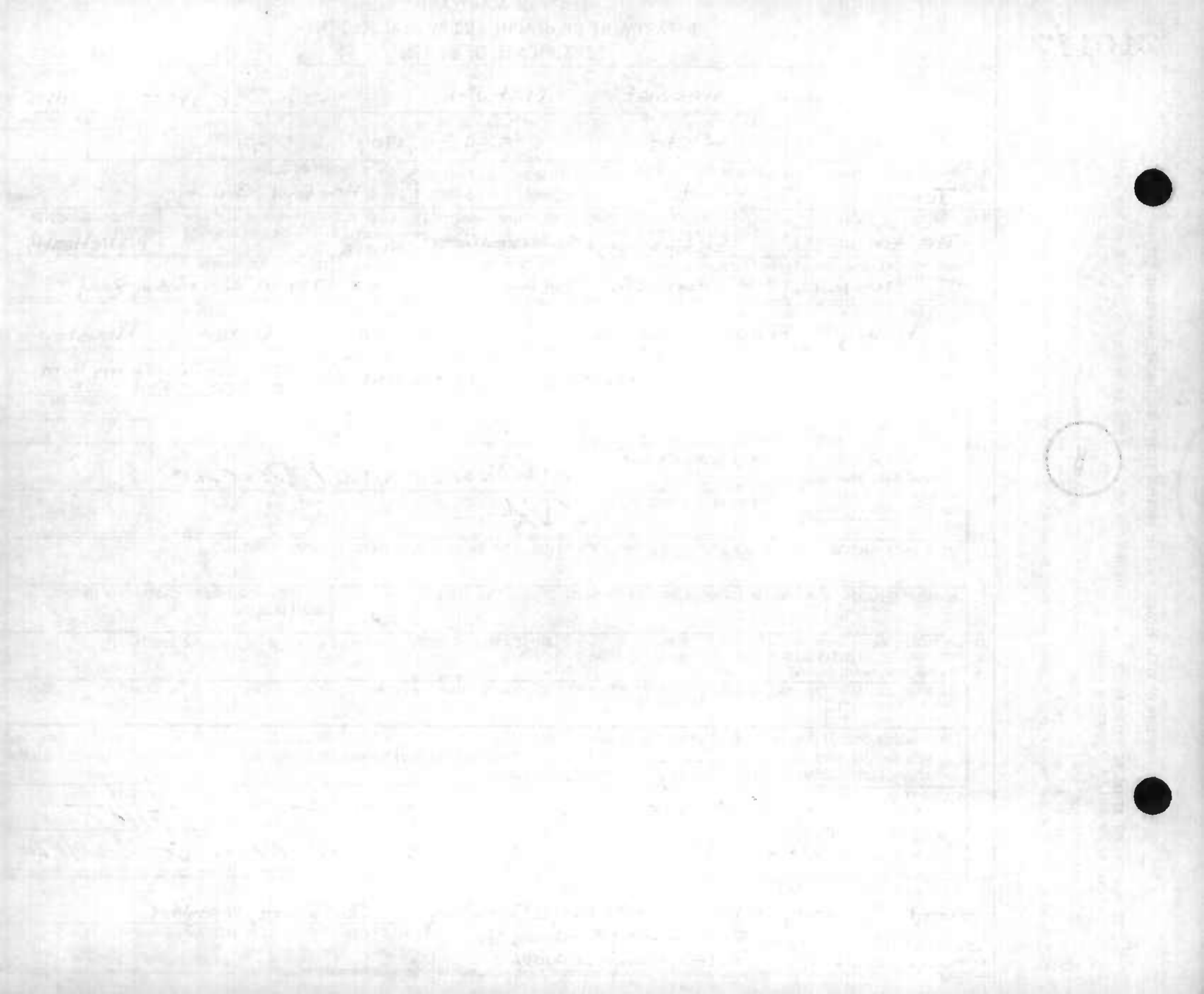
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE

### CERTIFICATE OF DEATH

85 20263

1. DECEASED-NAME (Type or print) <b>HELEN Harriet NATWICK</b>			2a. DATE OF DEATH Month <b>July</b> Day <b>20</b> Year <b>1985</b>			2b. HOUR <b>11:05</b> P <b>P</b> M				
3. SEX <b>FEMALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Sept. 24, 1907</b>		6. AGE (In years lost birthday) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>TENN.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Harford County,</b> Md.				
10. CITY OR TOWN OF DEATH <b>Bel Air</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Bel Air Nursing &amp; Convalescent Center</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Nurse</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Public Health</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Harford Co</b>		13c. CITY OR TOWN <b>Bel Air</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>734 W. Ring Factory Road</b>	
14. FATHER'S NAME First <b>Henry</b> Middle <b>Frank</b> Last <b>Natwick</b>			15. MOTHER'S MAIDEN NAME First <b>Laura</b> Middle <b>Ester</b> Last <b>Houston</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>220-14-2256-A</b>		17. INFORMANT (Brother) <b>877-3513</b> <b>Mr. Robert H. Natwick</b>			Address <b>734 West Ring Factory Road</b> <b>Bel Air, Maryland 21014</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF <b>Ischemic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>CVA</b> (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Andrew Nowakowski</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>7/21/85</b>		
22d. PHYSICIAN'S NAME (Type) <b>ANDREW NOWAKOWSKI MD</b>						22e. ADDRESS <b>125 N. MAIN ST. BEL AIR, MD</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>July 23, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>		
24. FUNERAL DIRECTOR <b>Joseph William Foster</b> <b>Superior Funeral</b>						50 W. Breakwater Dr. <b>Bel Air, Maryland 21014</b>		25a. REC'D BY REGISTRAR <b>DATE 7/23/85</b>		
								25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rendell</b>		







210107

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 REG. NO. 20264

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Sam Nusenfress</b>		2a. DATE OF DEATH MONTH <b>7</b> DAY <b>22</b> YEAR <b>85</b>		2b. HOUR <b>8:30</b> AM
3 SEX <b>Male</b>	4 RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH <b>10</b> DAY <b>10</b> YEAR <b>15</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Harford</b> MD.
10 CITY OR TOWN OF DEATH <b>Fallston</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Fallston General Hospital</b>		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>	12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>955 A Sablewood Rd 21014</b>
13a. STATE <b>MD</b>	13b. COUNTY <b>Harford</b>	13c. CITY OR TOWN <b>Bel Air</b>	

14. FATHER'S NAME FIRST <b>HUMAN</b> MIDDLE LAST <b>NUSEN PRESS</b>	15. MOTHER'S MAIDEN NAME FIRST <b>ANNA</b> MIDDLE LAST <b>UNK</b>
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16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII, K.V.N. 125 05 4603</b>	17 INFORMANT <b>PHYLLIS BRANCATO, 505 So. BANANA RIVER DRIVE 32952</b>	ADDRESS <b>MERRITT ISLAND, FLA.</b>
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18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b>
DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASAD, COPD, Sepsis</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Renal Failure, Recurrent Intestinal Obstruction, Massive Edema one week.</b>		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **one week.**

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION <b>7/21/85 7:30</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Recurrent Intestinal Obstruction</b>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
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21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE
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22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that (I) (we) last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <b>Willard P. Amoss</b>	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>7/22/85</b>
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22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Willard P. Amoss</b>	22e. ADDRESS <b>2303 Beloit Rd, Fallston, MD 21047</b>
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23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>	23b. DATE <b>JUL 22, 1985</b>	23c. NAME OF CEMETERY OR CREMATORY <b>R. A. FERRIS &amp; COMPANY</b>	23d. LOCATION CITY OR TOWN <b>West Chester</b> COUNTY <b>Chester</b> STATE <b>PENNA</b>
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24. FUNERAL DIRECTOR NAME <b>TARRING FUNERAL HOME, P.A., ABERDEEN, MD. 21001-3399</b>	25a. DATE REC'D. BY REGISTRAR <b>JUL 24 1985</b>	25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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214107

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, RELEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 5. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 4 AND 5 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR AIS ME (S))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 80265

1- STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE KNOWN OF DEATH			21. DATE OF DEATH			22. HOUR		
JAMES JOSEPH PETNIC						7-28-85			7-28-85			11:55 AM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR	8. IF UNDER 24 HRS.	23. DATE PRONOUNCED DEAD			24. HOUR			25. DATE REC'D. BY REGISTRAR		
MALE	CAUC.	09 15 10 74	YRS.	MONTHS	DAYS	7-28-85			11:55 AM			JUL 31 1985		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH		
MARYLAND			USA			NEVER MARRIED			Harford County			Joppa		
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			13a. STREET ADDRESS			13b. CITY OR TOWN		
301 Trimble Rd.			SHEET METAL			STEEL			301 TRIMBLE RD. APT 2B			JOPPA		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT		
JOSEPH			MARY			NO			213073920			ELIZABETH PETNIC 301 TRIMBLE RD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			19. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			21. HOW INJURY OCCURRED		
PART I DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			self/inflicted		
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.			(b)			DUE TO, OR AS A CONSEQUENCE OF								
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY			21c. PLACE OF INJURY			21d. LOCATION			21e. HOW INJURY OCCURRED		
10:30AM 7-28-85			home (bedrm)			301 Trimble Rd.			Joppa, Maryland			self/inflicted		
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .														
23a. BURIAL, CREMATION, REMOVAL			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			23e. REGISTRAR'S SIGNATURE		
BURIAL			8/1/85			MORELAND MEM.			BALTO.			BALTO. MD.		
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			25c. DATE REC'D. BY REGISTRAR			25d. REGISTRAR'S SIGNATURE		
Ship 3 Cont II			JUL 31 1985			na newson-jendall								

ACTUAL SIGNATURE

Margarita A. Korell, M.D.

TITLE (SPECIFY)

M.D. Assistant MEDICAL EXAMINER

DATE 7-29-85  
SIGNED

EXAMINER'S NAME (TYPE OR PRINT)

Margarita A. Korell, M.D.

ADDRESS 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL

BURIAL

23b. DATE

8/1/85

23c. NAME OF CEMETERY OR CREMATORY

MORELAND MEM.

23d. LOCATION

BALTO.

BALTO.

MD.

24. FUNERAL DIRECTOR

Ship 3 Cont II

ADDRESS

1211 Claver Ave

25a. DATE REC'D. BY REGISTRAR

JUL 31 1985

25b. REGISTRAR'S SIGNATURE

na newson-jendall

STATES

WAXLEY CO

NOTICE NO. 2

B

159128

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO. 8520260

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Eli Grace Reilly		2a. DATE OF DEATH MONTH DAY YEAR July 2 1985		2b. HOUR 5:30 P.M.	
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Feb. 7, 1912	
6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.			
10. CITY OR TOWN OF DEATH Haver de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NO IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
12b. KIND OF BUSINESS OR INDUSTRY		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md.			
13c. COUNTY Harford		13d. CITY OR TOWN Haver de Grace		13e. STREET ADDRESS / ZIP CODE 160 Revolution St. Apt. 610 21078	
14. FATHER'S NAME FIRST MIDDLE LAST Ernest Morgan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Sophie Traul			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 650-20-8472		17. INFORMANT ADDRESS Harry Brady, Sr., 1207 Mystic Ct., Churchville, MD, 21028	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Cerebro-vascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7-2, 1985, to 7-2, 1985, that (I) (we) last saw the deceased alive on 7-2, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Irvin Wachsman MD				22c. DATE SIGNED 7-2-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) IRVIN WACHSMAN				22e. ADDRESS Union Ave, Haver de Grace, Md. 21078	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial/Removal		23b. DATE July 5, 1985		23c. NAME OF CEMETERY OR CREMATORY Linden Hill Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Ridgewood, Queens, New York		24. FUNERAL DIRECTOR NAME ADDRESS Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399			
25a. DATE REC'D. BY REGISTRAR JUL 10 1985		25b. REGISTRAR'S SIGNATURE Lelia Davidson-Rodarte			

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214002

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 REG. NO. 20267

1. DECEASED NAME (TYPE OR PRINT) <b>HOWARD ROTH REMBOLD</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>7 27 85</b>		2b. HOUR <b>9:35 PM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 28, 1907</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b>		7. BIRTH PLACE (STATE OR FOREIGN COUNTRY) <b>Magnolia, Md.</b>		8. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>HARFORD</b> MD.		10. CITY OR TOWN OF DEATH <b>Fallston</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FALLSTON GEN Hosp</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Owner-Operator</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Gas Station</b>		13. STREET ADDRESS / ZIP CODE <b>512 Kenmore Avenue 21014</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles -- Rembold</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bessie -- Montgomery</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes WWII</b>	
16b. SOCIAL SECURITY NO. <b>212-03-5949</b>		17. INFORMANT <b>Mrs. Daisy L. Rembold</b>		ADDRESS <b>Md. 21014</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Renal Failure</b>		<b>1 month</b>
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Metastatic Colon CA</b>		<b>1 year</b>

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **no**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>July 27, 1985</b> to <b>July 27, 1985</b> , that (I) (we) last saw the deceased alive on <b>July 27, 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Joseph Levine</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>7/27/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Joseph Levine</b>				22e. ADDRESS <b>Fallston General Hospital</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 31, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens, Bel Air</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Harford Md.</b>	
24. FUNERAL DIRECTOR <b>Howard K. McComas III, Abingdon, Md. 21009</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 30 1985</b>		25b. REGISTRAR'S SIGNATURE <b>John Anderson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





210052

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 REG. NO. 20268

1. DECEASED NAME (TYPE OR PRINT) <b>CHRISTOPHER Charles RHINEHART</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 21 1985</b>			2b. HOUR <b>?</b> M				
1. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 3, 1948</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>37</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HARFORD</b> MD.				
10. CITY OR TOWN OF DEATH <b>JARRETTSVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2143 NELSON MILL Rd.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Pharmacist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Pharmacy</b>		
13a. STATE <b>Md.</b>			13b. CITY <b>HARFORD</b>		13c. CITY OR TOWN <b>JARRETTSVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>2143 Nelson Mill Rd. 21084</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert Russell Rhinehart</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mari Hess</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1969-1972</b>		17. INFORMANT ADDRESS <b>Robert R. Rhinehart same as above</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.**Cardiac Arrest****Ischemic heart disease**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

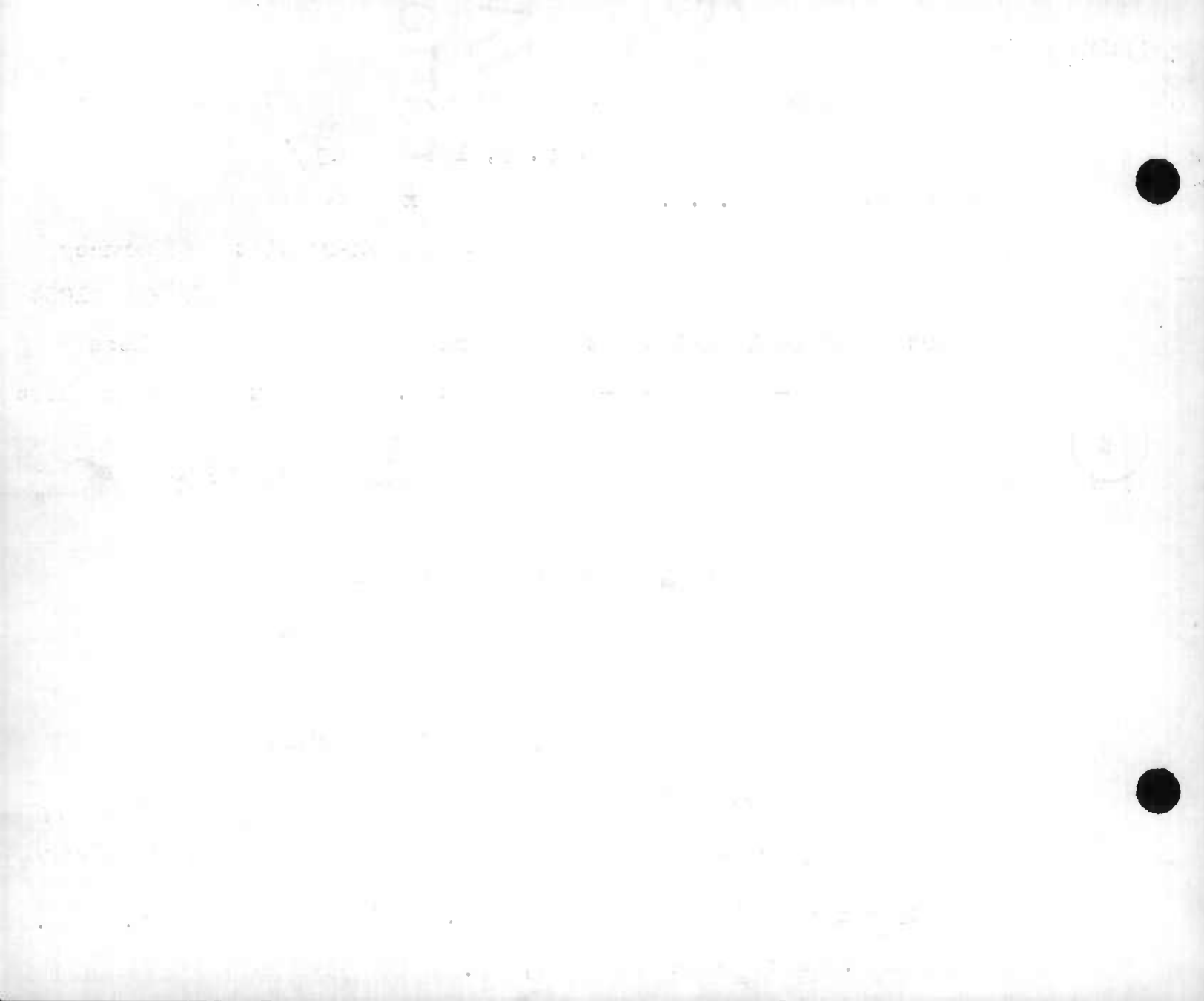
**Cerebral Brain damage**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>not attended</b> 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>7-20-85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>U.S. NAIR M.D.</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>7-20-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <b>1716 Hayford Road. Fellsch + Dela</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>7/22/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Balto. Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Benjamin W. Kurtz Jarrettsville, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 23 1985</b>			
				25b. REGISTRAR'S SIGNATURE <b>J. Davidson</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be returned by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove chain of custody. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP



198103

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 5 20269  
REG. NO.1 - FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>DOROTHY A. SHELLEY</b>			2a DATE OF DEATH MONTH DAY YEAR <b>7-14-85</b>		2b HOUR <b>12<sup>15</sup> P.M.</b>
3 SEX <b>F</b>	4 RACE <b>White</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>June 7, 1911</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Harford County</b> MD.	
10 CITY OR TOWN OF DEATH <b>Fallston</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Fallston General Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Office Work</b>	12b KIND OF BUSINESS OR INDUSTRY <b>Hutzler's</b>	
13a STATE <b>Maryland</b>			13b COUNTY <b>Harford</b>	13c CITY OR TOWN <b>Joppa</b>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST <b>J. Henry Gerwig</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Blanche Houston</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>217-34-3662A</b>		17 INFORMANT <b>John W. Shelley</b> ADDRESS <b>Joppa, Md. 21085</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CVA (Left) Infarction Cerebral E(R) hemisphere + aphasia</b> DUE TO, OR AS A CONSEQUENCE OF <b>-a Diabetes Mellitus Type I</b> DUE TO, OR AS A CONSEQUENCE OF <b>-b Hypertension - I. H. D.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>UTI - Left L-L infiltrate.</b>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <b>6/12/85</b> to <b>7/14/85</b> , that (I) (we) lost saw the deceased alive on <b>7/14/85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>D. L. Pirovolidis MD. PA</b>		DEGREE		22c. DATE SIGNED <b>7/14/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D L. PIROVOLIDIS</b>		22e. ADDRESS <b>1716 HARFORD Rd FALLSTON, Md. 21047</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jul 17 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc.</b>		ADDRESS <b>Baltimore, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 15 1985</b>	
		REGISTRAR'S SIGNATURE <b>John Davidson-Randell</b>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSMIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 20270

1- FOR STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2b. DATE KNOWN OF DEATH ESTI- MATED		MONTH	DAY	YEAR	2b. HOUR
198140		Charles Frederick Simons, Jr.					7- 9 1985					AM
3 SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		2d. HOUR
Male	White	Oct. 10, 1927		57 YRS.						7-10 1985		3:45 P. AM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Baltimore, Md.		USA				Harford County, MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Joppa		415 Latimer Road		Military		Retired						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS				
Maryland		Harford		Joppa				415 Latimer Road		21085		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
Charles Frederick Simons, Sr.		Nancy Gertrude Lafferty		214-22-4202		Mrs. Josephine D. Simons,		Joppa, Md. 21085		415 Latimer Road		
16b. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16c. (IF YES, GIVE WAR OR DATES)		17. ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Yes		1945-1972		214-22-4202		Mrs. Josephine D. Simons,		Joppa, Md. 21085		415 Latimer Road		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED								
Dennis F. Smyth, M.D.		Assistant		7-11-85								
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Dennis F. Smyth, M.D.		111 Penn St., Balto., Md. 21201		Burial		July 15, 1985		Arlington National Cem.		Arlington Va		
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
Howard K. McComas III, Abingdon, Md. 21009		JUL 15 1985		John Davidson-Brooks								

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the attending physician.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		85 REG. NO. 20271	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Ross Edward Smith Sr.		2. DATE OF DEATH MONTH DAY YEAR 7/23/85	
3. SEX male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 11/20/892	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.	
10. CITY OR TOWN OF DEATH Bel Air		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel Air Conv. Center		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Monkton	
14. FATHER'S NAME FIRST MIDDLE LAST Lewis		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Eck		12b. KIND OF BUSINESS OR INDUSTRY Farming	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-14-9928		17. INFORMANT ADDRESS Harold E. Smith White Hall, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic ill dwelling cathector / History of urosesix x 2 in last 6 mo.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3/1, 1985, to 7/23, 1985, that (I) (we) last saw the deceased alive on 7/21, 1985, and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE David W. McClure MD		22c. DATE SIGNED 7/27/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID W. McCLURE MD		22e. ADDRESS 1131 Bel Air Road Bel Air, Md 21014			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/26/1985		23c. NAME OF CEMETERY OR CREMATORY Vernon Cemetery	
24. FUNERAL DIRECTOR NAME M. Bladden Kuty III		ADDRESS Garrettsville, Md.		25a. DATE REC'D. BY REGISTRAR JUL 28 1985	
				25b. REGISTRAR'S SIGNATURE John Davidson-Rendell	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by telephone.

207019

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 REG. NO. 2 0 2 7 2

1 DECEASED NAME (TYPE OR PRINT) <b>Margaret ANN SPANN</b>			2a DATE OF DEATH MONTH DAY YEAR <b>July 18, 1985</b>		2b HOUR <b>8:30 A.M.</b>
3 SEX <b>FEMALE</b>	4 RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>AUGUST 24 1905</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>TEXAS</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>Harford</b> MD.		
10 CITY OR TOWN OF DEATH <b>Harre de Grace</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Harford Memorial Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MAIL CLERK</b>	12b KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>HARFORD</b>	13c. CITY OR TOWN <b>ABERDEEN</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM RISE SPANN</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>REGINA ENNIS</b>		16 STREET ADDRESS / ZIP CODE <b>691 CUSTIS STREET 21001</b>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. <b>216-12-6733</b>		17. INFORMANT ADDRESS <b>BELAIR, MD, 21014</b> <b>JOSEPHINE S. MAGNESS, 335 WEST GORDON, ST.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>cardiovascular heart disease, generalized atherosclerosis</b>					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (the hospital) attended the deceased from <b>7-15-85</b> , 19____, to <b>7-18-85</b> , 19____, that (I) (we) last saw the deceased alive on <b>7-18-85</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b SIGNATURE <b>B. J. Plunkett Jr M.D.</b>		22c. DATE SIGNED <b>7-19-85</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>B. J. PLUNKETT, JR. M.D.</b>	
22e ADDRESS <b>617 W. BEL AIR AVE. ABERDEEN, MD, 21001</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>20 JULY 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>IMMACULATE CONCEPTION</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>ELKTON CECIL MARYLAND</b>					
24 FUNERAL DIRECTOR NAME <b>TARRING FUNERAL HOME, PA.</b>		ADDRESS <b>ABERDEEN, MD, 21001-3399</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 23 1985</b>	
25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>					

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH1- FOR  
STATE  
REGISTRAR

8 5 REG. NO. 2 0 2 7 3

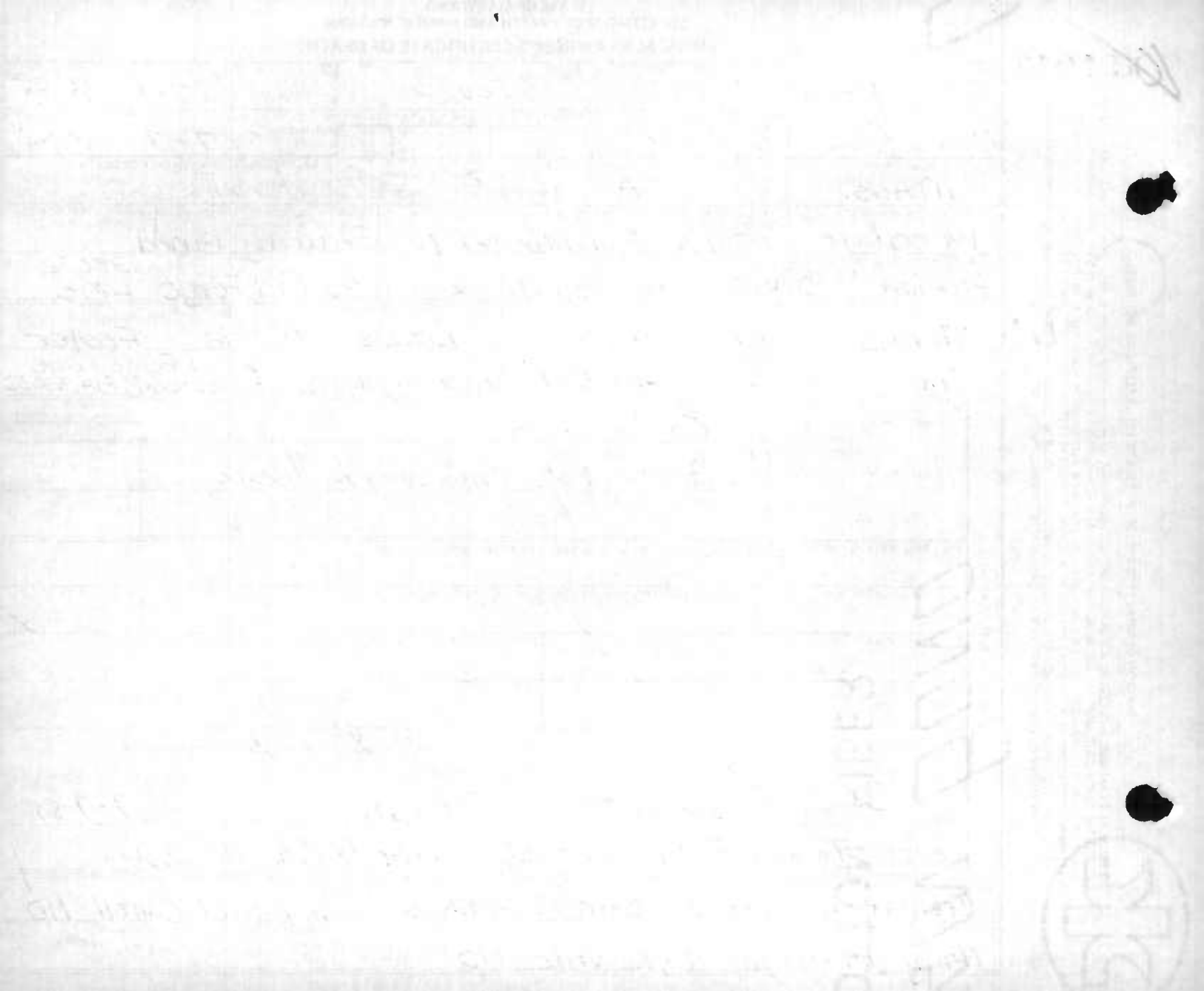
1 DECEASED NAME (TYPE OR PRINT) Grace STEELE		2a DATE OF DEATH MONTH DAY YEAR July 26 '85		2b HOUR 4 <sup>00</sup> AM	
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR 09 01 1914		6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.	
10 CITY OR TOWN OF DEATH FALLSTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) TALLSTON GENERAL HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY Home
13a STATE West Virginia		13b COUNTY Mingo	13c CITY OR TOWN Meador	13e STREET ADDRESS / ZIP CODE none 25682	
14 FATHER'S NAME FIRST MIDDLE LAST unknown		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Polly Bryant			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NONE 236-11-4489		17 INFORMANT ADDRESS Margie L. Coomes 2903 Smithson Drive Forest Hill, Maryland	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest with Ventricular Tachycardia DUE TO, OR AS A CONSEQUENCE OF (b) Acute pulmonary edema possibly associated with pulmonary thromboemboli. DUE TO, OR AS A CONSEQUENCE OF (c) Deep vein thrombosis, left lower extremity					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION July 25 '85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12) (13) (14) (15) (16) (17) (18) (19) (20) (21) (22) (23) (24) (25) (26) (27) (28) (29) (30) (31) (32) (33) (34) (35) (36) (37) (38) (39) (40) (41) (42) (43) (44) (45) (46) (47) (48) (49) (50) (51) (52) (53) (54) (55) (56) (57) (58) (59) (60) (61) (62) (63) (64) (65) (66) (67) (68) (69) (70) (71) (72) (73) (74) (75) (76) (77) (78) (79) (80) (81) (82) (83) (84) (85) (86) (87) (88) (89) (90) (91) (92) (93) (94) (95) (96) (97) (98) (99) (100) (101) (102) (103) (104) (105) (106) (107) (108) (109) (110) (111) (112) (113) (114) (115) (116) (117) (118) (119) (120) (121) (122) (123) (124) (125) (126) (127) (128) (129) (130) (131) (132) (133) (134) (135) (136) (137) (138) (139) (140) (141) (142) (143) (144) (145) (146) (147) (148) (149) (150) (151) (152) (153) (154) (155) (156) (157) (158) (159) (160) (161) (162) (163) (164) (165) (166) (167) (168) (169) (170) (171) (172) (173) (174) (175) (176) (177) 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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
FOR 1- STATE REGISTRAR											
REG. NO. 274											
1. DECEASED NAME (TYPE OR PRINT) <b>PAUL FOSTER STEVES</b>						2b. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> <b>7-7 1985</b>					
3. SEX <b>Male</b>		4. RACE <b>Cauc</b>		5. DATE OF BIRTH MONTH <b>5</b> DAY <b>8</b> YEAR <b>04</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>81</b> YRS.		IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MASS.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. BALTIMORE CITY OR COUNTY OF DEATH <b>HOWARD COUNTY</b>				10. CITY OR TOWN OF DEATH <b>Woodbine</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>15811A E. Mullinix Rd.</b>			
12. USUAL RESIDENCE (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Security Guard</b>				12b. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Security Guard</b>				12c. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>FLORIDA</b>				13b. COUNTY <b>Dade</b>				13c. CITY OR TOWN <b>Homestead</b>			
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS <b>36 Old Forge Lane</b>				13f. ZIP CODE <b>33032</b>			
14. FATHER'S NAME FIRST <b>Thomas</b> MIDDLE <b>Leroy</b> LAST <b>Steves</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Lizzie</b> MIDDLE <b>Maria</b> LAST <b>Foster</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>						16b. SOCIAL SECURITY NO. <b>021148537</b>					
17. INFORMANT <b>Ruth E. Steves</b>						17b. ADDRESS <b>36 Old Forge Lane Homestead, FLA, 33032</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Thomas F. Herbert</b>				TITLE (SPECIFY) <b>Deputy</b> M.D. MEDICAL EXAMINER				DATE SIGNED <b>7-7-85</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas F. Herbert, MD</b>				ADDRESS <b>Ellicott City Md 21043</b>							
23a. BURIAL, CREMATION, REMOVAL (TYPE) <b>Cremation</b>				23b. DATE <b>7-8-85</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Carroll Cremations</b>			
23d. LOCATION CITY OR TOWN <b>Hampstead</b> COUNTY <b>Carroll</b> STATE <b>MD</b>				23e. DATE REC'D. BY REGISTRAR <b>JUL 08 1985</b>				23f. REGISTRAR'S SIGNATURE <b>Charles Henderson-Hendell</b>			
24. FUNERAL DIRECTOR NAME <b>Harry W. Haight</b> ADDRESS <b>Sykesville, MD</b>				25. DATE REC'D. BY REGISTRAR <b>JUL 08 1985</b>							



159067

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO 20275

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
RICHARD PAUL Streett, SR					7	7	10	1985	12 PM
3 SEX	4 RACE	5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male	White	May 7, 1904		81	MONTHS		DAYS		HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Street, Maryland	USA			Harford County MD.					
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Bel Air	Bel Air Convalescent Center			Farmer		Beef-Grain			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE		
Maryland		Harford	Forest Hill			1526 Rock Spring Road 21050			

14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
John Walter Streett		Cassandra -- Ady	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17 INFORMANT ADDRESS	
No	-- 216-05-7732	Mrs. Mary C. Streett, 2827 College View Drive Churchville, Md. 21028	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Recurrent STROKE		3 days
DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension		15 yrs
DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROSIS		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)	
Pneumonia & Urinary Tract Infection	

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
------------------------	--	--	---

21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
--	--	---

21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE
--	--	---

22a. I certify that (I) (this hospital) attended the deceased from May 28, 1985, to July 10, 1985, that (I) (we) last saw the deceased alive on July 10, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.	
---	--

22b. SIGNATURE Dante U. Monakil M.D.	DEGREE M.D.	22c. DATE SIGNED 7/11/85
---	----------------	-----------------------------

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DANTE U. MONAKIL, M.D.	Harre de Grace, Md 21078

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	July 12, 1985	St. Ignatius Cemetery	Hickory Harford Md.

24 FUNERAL DIRECTOR NAME ADDRESS	25a. DATE RECEIVED BY REGISTRAR	25b. RECEIVED BY REGISTRAR
Howard K. McComas III, Abingdon, Md. 21009	JUL 12 1985	



3

11-11-12

11-11-12

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11-11-12

11-11-12



210082

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 REG. NO. 20276

1. DECEASED NAME (TYPE OR PRINT) <b>Glenn Sturgill</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 22, 1985</b>			2b. HOUR <b>3:25 PM</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 7 1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford</b> MD.				
10. CITY OR TOWN OF DEATH <b>Darlington</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3741 Dublin Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Harford</b>		13c. CITY OR TOWN <b>Darlington</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>3741 Dublin Road 21034</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Sturgill</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mattie Edwards</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO <b>239-18-1060</b>		17. INFORMANT ADDRESS <b>Rt 1 Box 152 Kingwood Linda S. Sturgill West Virginia</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>metastatic lung cancer</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) this hospital attended the deceased from <b>5/22/85</b> , 19 <b>85</b> , to <b>7/22</b> , 19 <b>85</b> , that (1) (we) lost saw the deceased alive on <b>7/21</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Charles Padgett</b>					DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>7/23/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Charles Padgett</b>					22e. ADDRESS <b>5601 Loch Raven Blvd.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>July 26, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gds.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bel Air Harford Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Howard K. McComas III Abingdon, Maryland</b>					25. DATE RECD. BY REGISTRAR <b>JUL 24 1985</b>			26. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

MEDICAL CERTIFICATION



Handwritten text, possibly a date or reference number, oriented vertically. It appears to read '10/10/15' or similar, with some additional markings.

Handwritten text at the bottom left, possibly a date or reference number. It appears to read '10/10/15' or similar, with some additional markings.

Small handwritten text or signature at the bottom left.

210230

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. (GVF PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 78A.3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M
 BP  
DHMH - 17  
(VR A15 ME (5))
1- FOR  
STATE  
REGISTRAR
 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 20271

1. DECEASED NAME (TYPE OR PRINT)			FIRST Mark			MIDDLE A.			LAST Tegges			2b. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR			7 21 1985			2d HOUR M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) (LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD			7 21 1985			5:55P M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH								
Maryland				U.S.A.								Harford County MD								
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY				
Fallston				Fallston General Hospital								Canner--Beverage				Capital				
13a. STATE				13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS						21220						
Maryland				Baltimore		Middle River		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 1300 Burke Road												
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST																
Charles E. Tegges				Carole J. Moyer																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS														
Yes				1979-1982		218-80-0506				Charles E. Tegges				Same as 13e						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																				
PART 1 DEATH WAS CAUSED BY:																				
IMMEDIATE CAUSE (a) <u>Drowning</u>																				
DUE TO, OR AS A CONSEQUENCE OF																				
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																				
(b) _____																				
DUE TO, OR AS A CONSEQUENCE OF																				
(c) _____																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.																				
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?								
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
				4:40 P.M. 7 21 1985				Subject drowned while swimming												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
				quarry				Peach Bottom Rd, Delta				PA.								
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																				
ACTUAL SIGNATURE				TITLE (SPECIFY)								DATE SIGNED								
				M.D. Assistant MEDICAL EXAMINER								7/23/85								
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																
Ann M. Dixon, M.D.				111 Penn St. Balto.MD.																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE										
Burial				7/26/1985		Holly Hill				White Marsh Maryland										
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE												
Duda-Ruck, Inc.				JUL 25 1985																
7922 Wise Avenue				Dundalk, Maryland 21222																

MEDICAL CERTIFICATION

228 COLONY BLUE

W. F. W. D. W. D.



228

203437

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 5 REG. NO. 2 0 2 7 8	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RODGER D TESTERMAN		2a. DATE OF DEATH MONTH DAY YEAR 7-9-85		2b. HOUR 11 36 AM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec. 11 1950		6. AGE (IN YEARS LAST BIRTHDAY) 34 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
10. CITY OR TOWN OF DEATH FALLSTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Automobile
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Harford	13c. CITY OR TOWN Whiteford	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Edison Cleveland Testerman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Barker		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 216-56-5959		17. INFORMANT ADDRESS Blanche C. Testerman 1597 Main St. Whiteford MD 21160			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac tamponade</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute hemopericardium</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7-8</u> 19 <u>85</u> , to <u>7-9</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>7-8</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>M. S. SHARAF EL-DEANE</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. S. SHARAF EL-DEANE		22e. ADDRESS P.O. BOX 935 Edgewood, Md 21040			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 13, 1985		23c. NAME OF CEMETERY OR CREMATORY Mt. Vernon Cem.	
23d. LOCATION CITY OR TOWN Whiteford, Maryland		23e. COUNTY Harford		23f. STATE MD	
24. FUNERAL DIRECTOR NAME John H. Harkins 600 Main Street Delta, PA 17314		ADDRESS		25a. DATE REC'D. BY REGISTRAR JUL 12 1985	
				25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>	

BP

DHMH - 16 25M

(VR A 15 (4) 9/74)

The first part of the report  
 describes the general situation  
 of the country and the  
 results of the survey.  
 The second part of the report  
 describes the results of the  
 survey and the conclusions  
 drawn from it.

The third part of the report  
 describes the results of the  
 survey and the conclusions  
 drawn from it. The fourth  
 part of the report describes  
 the results of the survey  
 and the conclusions drawn  
 from it. The fifth part of  
 the report describes the  
 results of the survey and  
 the conclusions drawn from  
 it.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must examine the individual as above.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR										
1. DECEASED NAME (TYPE OR PRINT) <b>Henry F Turcotte</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>July 26, 1985</b>					
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 8, 1918</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.		7b. HOUR <b>2:50 P</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MASS</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford</b> MD.			
10. CITY OR TOWN OF DEATH <b>Havre de Grace</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Harford Memorial Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>(RET) STOCK CLERK</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>FED. GOVT.</b>		
13a. STATE <b>MD</b>					13b. COUNTY <b>CECIL</b>		13c. CITY OR TOWN <b>CONOWINGO</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph PHILIP TERCOTTE</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ROSE EMMA GAMACHE</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>013 16 5156</b>		17. INFORMANT <b>MRS. MARIE W. TURCOTTE</b>			ADDRESS <b>SAME AS #13e</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>CC PP &amp; respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiopulmonary thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTINUING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>J. Lee</b>		DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>7/26/85</b>		
22d. PHYSICIAN'S NAME <b>J. Lee</b>		22e. ADDRESS <b>Harford Memorial Hospital - Havre de Grace</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>31 JULY 85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OKLINGTON CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>DARLINGTON, HARFORD CO., MARYLAND</b>				
24. FUNERAL DIRECTOR NAME ADDRESS <b>MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MO. 21078</b>					25a. DATE REC'D. BY REGISTRAR <b>JUL 29 1985</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION

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213003

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 5 2 0 2 8 0  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Jerena L. Vincenti</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>July 26 1985</i>		2b. HOUR <i>10:30 P.M.</i>		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR <i>JUNE 16, 1906</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <i>79</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ITALY		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford</i> MD.	
10. CITY OR TOWN OF DEATH <i>Havre de Grace</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Harford Memorial Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (RET) SELF-EMPLOYED		12b. KIND OF BUSINESS OR INDUSTRY GROCERY STORE	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE MD		13b. COUNTY HARFORD		13c. CITY OR TOWN HAVRE de GRACE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST VINCENZO LEONARDI		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERNADINE LEVI		13e. STREET ADDRESS / ZIP CODE 616 ERIE STREET 21078			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218 32 2976		17. INFORMANT ADDRESS BERNADINE VINCENTI 608 ERIE STREET HAVRE de GRACE, MD.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>[Signature]</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>7/27/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>AMAKOVA M.D.</i>		22e. ADDRESS <i>319 S. Union Ave. Havre de Grace Md.</i>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 30 JULY 85		23c. NAME OF CEMETERY OR CREMATORY MT. ERIN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE HAVRE de GRACE, HARFORD CO., MARYLAND 21078	
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD 21078				25a. DATE REC'D BY REGISTRAR JUL 29 1985		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove completed Pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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200 COTTON



214096

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE AGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THIS FORM. PAGE 3, RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR		REG. NO. 20281	
1 DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH	
FIRST MIDDLE LAST Ward McLean Wagner		X MONTH DAY YEAR 7/ 25/ 19 85	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)
MALE	White	MONTH DAY YEAR June 5, 1965	LAST BIRTHDAY 20 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	
Maryland		U.S.A.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	
Fallston (21047)		310 308 Old Joppa Road	
13a. STATE		13b. CITY OR TOWN	
Maryland		Fallston	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
FIRST MIDDLE LAST Robert Alexander Wagner, Sr.		FIRST MIDDLE LAST Carol JEANNE McLEAN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.	
(YES, NO, OR UNKNOWN) NO		(IF YES, GIVE WAR OR DATES) 214-70-7786	
17. INFORMANT		18. CAUSE OF DEATH	
(Grandfather) 877-3037 Mr. O. Barton McLEAN		PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound to Head DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY	
21c. HOW INJURY OCCURRED		21d. INJURY OCCURRED	
21e. PLACE OF INJURY		21f. LOCATION	
21g. DATE RECD. BY REGISTRAR		21h. REGISTRAR'S SIGNATURE	
21i. DATE RECD. BY REGISTRAR		21j. REGISTRAR'S SIGNATURE	
21k. DATE RECD. BY REGISTRAR		21l. REGISTRAR'S SIGNATURE	
21m. DATE RECD. BY REGISTRAR		21n. REGISTRAR'S SIGNATURE	
21o. DATE RECD. BY REGISTRAR		21p. REGISTRAR'S SIGNATURE	
21q. DATE RECD. BY REGISTRAR		21r. REGISTRAR'S SIGNATURE	
21s. DATE RECD. BY REGISTRAR		21t. REGISTRAR'S SIGNATURE	
21u. DATE RECD. BY REGISTRAR		21v. REGISTRAR'S SIGNATURE	
21w. DATE RECD. BY REGISTRAR		21x. REGISTRAR'S SIGNATURE	
21y. DATE RECD. BY REGISTRAR		21z. REGISTRAR'S SIGNATURE	
21aa. DATE RECD. BY REGISTRAR		21ab. REGISTRAR'S SIGNATURE	
21ac. DATE RECD. BY REGISTRAR		21ad. REGISTRAR'S SIGNATURE	
21ae. DATE RECD. BY REGISTRAR		21af. REGISTRAR'S SIGNATURE	
21ag. DATE RECD. BY REGISTRAR		21ah. REGISTRAR'S SIGNATURE	
21ai. DATE RECD. BY REGISTRAR		21aj. REGISTRAR'S SIGNATURE	
21ak. DATE RECD. BY REGISTRAR		21al. REGISTRAR'S SIGNATURE	
21am. DATE RECD. BY REGISTRAR		21an. REGISTRAR'S SIGNATURE	
21ao. DATE RECD. BY REGISTRAR		21ap. REGISTRAR'S SIGNATURE	
21aq. DATE RECD. BY REGISTRAR		21ar. REGISTRAR'S SIGNATURE	
21as. DATE RECD. BY REGISTRAR		21at. REGISTRAR'S SIGNATURE	
21au. DATE RECD. BY REGISTRAR		21av. REGISTRAR'S SIGNATURE	
21aw. DATE RECD. BY REGISTRAR		21ax. REGISTRAR'S SIGNATURE	
21ay. DATE RECD. BY REGISTRAR		21az. REGISTRAR'S SIGNATURE	
21ba. DATE RECD. BY REGISTRAR		21bb. REGISTRAR'S SIGNATURE	
21bc. DATE RECD. BY REGISTRAR		21bd. REGISTRAR'S SIGNATURE	
21be. DATE RECD. BY REGISTRAR		21bf. REGISTRAR'S SIGNATURE	
21bg. DATE RECD. BY REGISTRAR		21bh. REGISTRAR'S SIGNATURE	
21bi. DATE RECD. BY REGISTRAR		21bj. REGISTRAR'S SIGNATURE	
21bk. DATE RECD. BY REGISTRAR		21bl. REGISTRAR'S SIGNATURE	
21bm. DATE RECD. BY REGISTRAR		21bn. REGISTRAR'S SIGNATURE	
21bo. DATE RECD. BY REGISTRAR		21bp. REGISTRAR'S SIGNATURE	
21bq. DATE RECD. BY REGISTRAR		21br. REGISTRAR'S SIGNATURE	
21bs. DATE RECD. BY REGISTRAR		21bt. REGISTRAR'S SIGNATURE	
21bu. DATE RECD. BY REGISTRAR		21bv. REGISTRAR'S SIGNATURE	
21bw. DATE RECD. BY REGISTRAR		21bx. REGISTRAR'S SIGNATURE	
21by. DATE RECD. BY REGISTRAR		21bz. REGISTRAR'S SIGNATURE	
21ca. DATE RECD. BY REGISTRAR		21cb. REGISTRAR'S SIGNATURE	
21cc. DATE RECD. BY REGISTRAR		21cd. REGISTRAR'S SIGNATURE	
21ce. DATE RECD. BY REGISTRAR		21cf. REGISTRAR'S SIGNATURE	
21cg. DATE RECD. BY REGISTRAR		21ch. REGISTRAR'S SIGNATURE	
21ci. DATE RECD. BY REGISTRAR		21cj. REGISTRAR'S SIGNATURE	
21ck. DATE RECD. BY REGISTRAR		21cl. REGISTRAR'S SIGNATURE	
21cm. DATE RECD. BY REGISTRAR		21cn. REGISTRAR'S SIGNATURE	
21co. DATE RECD. BY REGISTRAR		21cp. REGISTRAR'S SIGNATURE	
21cq. DATE RECD. BY REGISTRAR		21cr. REGISTRAR'S SIGNATURE	
21cs. DATE RECD. BY REGISTRAR		21ct. REGISTRAR'S SIGNATURE	
21cu. DATE RECD. BY REGISTRAR		21cv. REGISTRAR'S SIGNATURE	
21cw. DATE RECD. BY REGISTRAR		21cx. REGISTRAR'S SIGNATURE	
21cy. DATE RECD. BY REGISTRAR		21cz. REGISTRAR'S SIGNATURE	
21da. DATE RECD. BY REGISTRAR		21db. REGISTRAR'S SIGNATURE	
21dc. DATE RECD. BY REGISTRAR		21dd. REGISTRAR'S SIGNATURE	
21de. DATE RECD. BY REGISTRAR		21df. REGISTRAR'S SIGNATURE	
21dg. DATE RECD. BY REGISTRAR		21dh. REGISTRAR'S SIGNATURE	
21di. DATE RECD. BY REGISTRAR		21dj. REGISTRAR'S SIGNATURE	
21dk. DATE RECD. BY REGISTRAR		21dl. REGISTRAR'S SIGNATURE	
21dm. DATE RECD. BY REGISTRAR		21dn. REGISTRAR'S SIGNATURE	
21do. DATE RECD. BY REGISTRAR		21dp. REGISTRAR'S SIGNATURE	
21dq. DATE RECD. BY REGISTRAR		21dr. REGISTRAR'S SIGNATURE	
21ds. DATE RECD. BY REGISTRAR		21dt. REGISTRAR'S SIGNATURE	
21du. DATE RECD. BY REGISTRAR		21dv. REGISTRAR'S SIGNATURE	
21dw. DATE RECD. BY REGISTRAR		21dx. REGISTRAR'S SIGNATURE	
21dy. DATE RECD. BY REGISTRAR		21dz. REGISTRAR'S SIGNATURE	
21ea. DATE RECD. BY REGISTRAR		21eb. REGISTRAR'S SIGNATURE	
21ec. DATE RECD. BY REGISTRAR		21ed. REGISTRAR'S SIGNATURE	
21ee. DATE RECD. BY REGISTRAR		21ef. REGISTRAR'S SIGNATURE	
21eg. DATE RECD. BY REGISTRAR		21eh. REGISTRAR'S SIGNATURE	
21ei. DATE RECD. BY REGISTRAR		21ej. REGISTRAR'S SIGNATURE	
21ek. DATE RECD. BY REGISTRAR		21el. REGISTRAR'S SIGNATURE	
21em. DATE RECD. BY REGISTRAR		21en. REGISTRAR'S SIGNATURE	
21eo. DATE RECD. BY REGISTRAR		21ep. REGISTRAR'S SIGNATURE	
21eq. DATE RECD. BY REGISTRAR		21er. REGISTRAR'S SIGNATURE	
21es. DATE RECD. BY REGISTRAR		21et. REGISTRAR'S SIGNATURE	
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21fc. DATE RECD. BY REGISTRAR		21fd. REGISTRAR'S SIGNATURE	
21fe. DATE RECD. BY REGISTRAR		21ff. REGISTRAR'S SIGNATURE	
21fg. DATE RECD. BY REGISTRAR		21fh. REGISTRAR'S SIGNATURE	
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21fk. DATE RECD. BY REGISTRAR		21fl. REGISTRAR'S SIGNATURE	
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21fq. DATE RECD. BY REGISTRAR		21fr. REGISTRAR'S SIGNATURE	
21fs. DATE RECD. BY REGISTRAR		21ft. REGISTRAR'S SIGNATURE	
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21gc. DATE RECD. BY REGISTRAR		21gd. REGISTRAR'S SIGNATURE	
21ge. DATE RECD. BY REGISTRAR		21gf. REGISTRAR'S SIGNATURE	
21gg. DATE RECD. BY REGISTRAR		21gh. REGISTRAR'S SIGNATURE	
21gi. DATE RECD. BY REGISTRAR		21gj. REGISTRAR'S SIGNATURE	
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21hm. DATE RECD. BY REGISTRAR		21hn. REGISTRAR'S SIGNATURE	
21ho. DATE RECD. BY REGISTRAR		21hp. REGISTRAR'S SIGNATURE	
21hq. DATE RECD. BY REGISTRAR		21hr. REGISTRAR'S SIGNATURE	
21hs. DATE RECD. BY REGISTRAR		21ht. REGISTRAR'S SIGNATURE	
21hu. DATE RECD. BY REGISTRAR		21hv. REGISTRAR'S SIGNATURE	
21hw. DATE RECD. BY REGISTRAR		21hx. REGISTRAR'S SIGNATURE	
21hy. DATE RECD. BY REGISTRAR		21hz. REGISTRAR'S SIGNATURE	
21ia. DATE RECD. BY REGISTRAR		21ib. REGISTRAR'S SIGNATURE	
21ic. DATE RECD. BY REGISTRAR		21id. REGISTRAR'S SIGNATURE	
21ie. DATE RECD. BY REGISTRAR		21if. REGISTRAR'S SIGNATURE	
21ig. DATE RECD. BY REGISTRAR		21ih. REGISTRAR'S SIGNATURE	
21ii. DATE RECD. BY REGISTRAR		21ij. REGISTRAR'S SIGNATURE	
21ik. DATE RECD. BY REGISTRAR		21il. REGISTRAR'S SIGNATURE	
21im. DATE RECD. BY REGISTRAR		21in. REGISTRAR'S SIGNATURE	
21io. DATE RECD. BY REGISTRAR		21ip. REGISTRAR'S SIGNATURE	
21iq. DATE RECD. BY REGISTRAR		21ir. REGISTRAR'S SIGNATURE	
21is. DATE RECD. BY REGISTRAR		21it. REGISTRAR'S SIGNATURE	
21iu. DATE RECD. BY REGISTRAR		21iv. REGISTRAR'S SIGNATURE	
21iw. DATE RECD. BY REGISTRAR		21ix. REGISTRAR'S SIGNATURE	
21iy. DATE RECD. BY REGISTRAR		21iz. REGISTRAR'S SIGNATURE	
21ja. DATE RECD. BY REGISTRAR		21jb. REGISTRAR'S SIGNATURE	
21jc. DATE RECD. BY REGISTRAR		21jd. REGISTRAR'S SIGNATURE	
21je. DATE RECD. BY REGISTRAR		21jf. REGISTRAR'S SIGNATURE	
21jg. DATE RECD. BY REGISTRAR		21jh. REGISTRAR'S SIGNATURE	
21ji. DATE RECD. BY REGISTRAR		21jj. REGISTRAR'S SIGNATURE	
21jk. DATE RECD. BY REGISTRAR		21jl. REGISTRAR'S SIGNATURE	
21jm. DATE RECD. BY REGISTRAR		21jn. REGISTRAR'S SIGNATURE	
21jo. DATE RECD. BY REGISTRAR		21jp. REGISTRAR'S SIGNATURE	
21jq. DATE RECD. BY REGISTRAR		21jr. REGISTRAR'S SIGNATURE	
21js. DATE RECD. BY REGISTRAR		21jt. REGISTRAR'S SIGNATURE	
21ju. DATE RECD. BY REGISTRAR		21jv. REGISTRAR'S SIGNATURE	
21jw. DATE RECD. BY REGISTRAR		21jx. REGISTRAR'S SIGNATURE	
21jy. DATE RECD. BY REGISTRAR		21jz. REGISTRAR'S SIGNATURE	
21ka. DATE RECD. BY REGISTRAR		21kb. REGISTRAR'S SIGNATURE	
21kc. DATE RECD. BY REGISTRAR		21kd. REGISTRAR'S SIGNATURE	
21ke. DATE RECD. BY REGISTRAR		21kf. REGISTRAR'S SIGNATURE	
21kg. DATE RECD. BY REGISTRAR		21kh. REGISTRAR'S SIGNATURE	
21ki. DATE RECD. BY REGISTRAR		21kj. REGISTRAR'S SIGNATURE	
21kk. DATE RECD. BY REGISTRAR		21kl. REGISTRAR'S SIGNATURE	
21km. DATE RECD. BY REGISTRAR		21kn. REGISTRAR'S SIGNATURE	
21ko. DATE RECD. BY REGISTRAR		21kp. REGISTRAR'S SIGNATURE	
21kq. DATE RECD. BY REGISTRAR		21kr. REGISTRAR'S SIGNATURE	
21ks. DATE RECD. BY REGISTRAR		21kt. REGISTRAR'S SIGNATURE	
21ku. DATE RECD. BY REGISTRAR		21kv. REGISTRAR'S SIGNATURE	
21kw. DATE RECD. BY REGISTRAR		21kx. REGISTRAR'S SIGNATURE	
21ky. DATE RECD. BY REGISTRAR		21kz. REGISTRAR'S SIGNATURE	
21la. DATE RECD. BY REGISTRAR		21lb. REGISTRAR'S SIGNATURE	
21lc. DATE RECD. BY REGISTRAR		21ld. REGISTRAR'S SIGNATURE	
21le. DATE RECD. BY REGISTRAR		21lf. REGISTRAR'S SIGNATURE	
21lg. DATE RECD. BY REGISTRAR		21lh. REGISTRAR'S SIGNATURE	
21li. DATE RECD. BY REGISTRAR		21lj. REGISTRAR'S SIGNATURE	
21lk. DATE RECD. BY REGISTRAR		21ll. REGISTRAR'S SIGNATURE	
21lm. DATE RECD. BY REGISTRAR		21ln. REGISTRAR'S SIGNATURE	
21lo. DATE RECD. BY REGISTRAR		21lp. REGISTRAR'S SIGNATURE	
21lq. DATE RECD. BY REGISTRAR		21lr. REGISTRAR'S SIGNATURE	
21ls. DATE RECD. BY REGISTRAR		21lt. REGISTRAR'S SIGNATURE	
21lu. DATE RECD. BY REGISTRAR		21lv. REGISTRAR'S SIGNATURE	
21lw. DATE RECD. BY REGISTRAR		21lx. REGISTRAR'S SIGNATURE	
21ly. DATE RECD. BY REGISTRAR		21lz. REGISTRAR'S SIGNATURE	
21ma. DATE RECD. BY REGISTRAR		21mb. REGISTRAR'S SIGNATURE	
21mc. DATE RECD. BY REGISTRAR		21md. REGISTRAR'S SIGNATURE	
21me. DATE RECD. BY REGISTRAR		21mf. REGISTRAR'S SIGNATURE	
21mg. DATE RECD. BY REGISTRAR		21mh. REGISTRAR'S SIGNATURE	
21mi. DATE RECD. BY REGISTRAR		21mj. REGISTRAR'S SIGNATURE	
21mk. DATE RECD. BY REGISTRAR		21ml. REGISTRAR'S SIGNATURE	
21mo. DATE RECD. BY REGISTRAR		21mp. REGISTRAR'S SIGNATURE	
21mq. DATE RECD. BY REGISTRAR		21mr. REGISTRAR'S SIGNATURE	
21ms. DATE RECD. BY REGISTRAR		21mt. REGISTRAR'S SIGNATURE	
21mu. DATE RECD. BY REGISTRAR		21mv. REGISTRAR'S SIGNATURE	
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21ns. DATE RECD. BY REGISTRAR		21nt. REGISTRAR'S SIGNATURE	
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21pk. DATE RECD. BY REGISTRAR		21pl. REGISTRAR'S SIGNATURE	
21po. DATE RECD. BY REGISTRAR		21pp. REGISTRAR'S SIGNATURE	
21pq. DATE RECD. BY REGISTRAR		21pr. REGISTRAR'S SIGNATURE	
21ps. DATE RECD. BY REGISTRAR		21pt. REGISTRAR'S SIGNATURE	
21pu. DATE RECD. BY REGISTRAR		21pv. REGISTRAR'S SIGNATURE	
21pw. DATE RECD. BY REGISTRAR		21px. REGISTRAR'S SIGNATURE	
21py. DATE RECD. BY REGISTRAR		21pz. REGISTRAR'S SIGNATURE	
21qa. DATE RECD. BY REGISTRAR		21qb. REGISTRAR'S SIGNATURE	
21qc. DATE RECD. BY REGISTRAR		21qd. REGISTRAR'S SIGNATURE	
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21qg. DATE RECD. BY REGISTRAR		21qh. REGISTRAR'S SIGNATURE	
21qi. DATE RECD. BY REGISTRAR		21qj. REGISTRAR'S SIGNATURE	
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21rq. DATE RECD. BY REGISTRAR		21rr. REGISTRAR'S SIGNATURE	
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21ru. DATE RECD. BY REGISTRAR		21rv. REGISTRAR'S SIGNATURE	
21rw. DATE RECD. BY REGISTRAR		21rx. REGISTRAR'S SIGNATURE</	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove categories Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
FOR Film G609 item2b 1- STATE 11/15/85 rja REGISTRAR					8 5 REG. NO. 3 0 2 8 2					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BERTHA REBECCA WANN					2a. DATE OF DEATH MONTH DAY YEAR 7 31 1985 2b. HOUR 10:10AM 9:55AM					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 23, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Uontown, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.				
10. CITY OR TOWN OF DEATH HAVRE DE GRACE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITIZENS NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY --		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James Milton Shriner					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Flora Belle Leister					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --		17. INFORMANT Doris W. Wann, 137 Williams St., Bel Air, Md.		ADDRESS 21014				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio respiratory arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebrovascular insufficiency</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary artery disease</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Intermittent cardiac arrhythmia</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>9-8-</u> 19 <u>83</u> , to <u>7-31-</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>7-31</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>[Signature]</i>					22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) 319 S. UNION AVE. HDG, MD. 21078					22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 3, 1985		23c. NAME OF CEMETERY OR CREMATORY Mountain Christian Cemetery, Joppa		23d. LOCATION CITY OR TOWN COUNTY STATE Harford Md.				
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009					25a. DATE REC'D. BY REGISTRAR AUG 1 1985					
					25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHHM - 17  
(VR A15 ME (5))1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2 8 3

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
William J. Ward			6 27 1985			10:20		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD
MALE	WHITE	FEB. 4 1950	35 YRS.					6 27 1985
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
DELAWARE	U.S.A.				Harford County, MD.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Havre de Grace			Harford Memorial Hospital					CONSTRUCTION
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE	13b. CITY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS				
MARYLAND	HARFORD	ABERDEEN	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	706 PLATER STREET 21001				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
WILLIAM B. WARD			PHYLLIS JULIAN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO			220-52-3030		PHYLLIS J. WARD, 706 PLATER ST, ABERDEEN, MD, 21001			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Narcotism								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:								
(b) DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
			HOUR A.M. MONTH DAY YEAR					
			P.M. 19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION			
					STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE			TITLE (SPECIFY)				DATE SIGNED	
			M.D. Acting Chief				6/29/85	
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
Thomas D. Smith, M.D.			111 Penn St. Balto. MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
BURIAL			1 JULY 1985		HARFORD MEM. GARDENS		ABERDEEN	
							HARFORD MD.	
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
TARRING FUNERAL HOME, P.A., ABERDEEN, MD, 21001-3399			JUL 05 1985		Julia Davidson-Randall			

MEDICAL CERTIFICATION



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WALKER

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1000 S. MICHIGAN AVE. CHICAGO, ILL. 60607



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT WARREN WARFEL						2a. DATE OF DEATH MONTH DAY YEAR JULY 26, 1985		2b. HOUR 5 (AM)		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 24, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.				
10. CITY OR TOWN OF DEATH HAVRE de GRACE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 616 SOUTH WASHINGTON STREET				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (RET) PROCURMENTOFF.		12b. KIND OF BUSINESS OR INDUSTRY (APG) FED GOVT.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY HARFORD		13c. CITY OR TOWN HAVRE de GRACE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 616 SOUTH WASHINGTON STREET 21078	
14. FATHER'S NAME FIRST MIDDLE LAST HENRY CLAY WARFEL				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY JANE LAWDER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217 05 1779		17. INFORMANT ADDRESS MRS. H. MARIE WARFEL SAME AS #13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio-pulmonary failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>adenocarcinoma of colon</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 9, 1984</u> to <u>July 26, 1985</u> , that (I) (we) lost saw the deceased alive on <u>26 July 1985</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>L. Silverstein MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LOUIS SILVERSTEIN, M.D.				22e. ADDRESS 203 SOUTH WASHINGTON STREET HAVRE de GRACE, MD. 21078						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 29 JULY 85		23c. NAME OF CEMETERY OR CREMATORY ANGEL HILL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE HAVRE de GRACE, HARFORD CO., MD.			
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078					25a. DATE REC'D. BY REGISTRAR JUL 30 1985		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>			

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*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "RECEIVED" and "DATE" are visible.]*

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 REG. NO. 20285

1. DECEASED NAME (TYPE OR PRINT) <b>Jesse HORACE Watters</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 27 1985</b>		2b. HOUR <b>7:55 P</b>	
3. SEX <b>M</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 - 18 - 1921</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b>		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		8. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford</b>		10. CITY OR TOWN OF DEATH <b>Harford</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Harford Memorial Hospital</b>		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY		13. STREET ADDRESS / ZIP CODE <b>711 Nottingham Dr. 21001</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel Watters</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lena</b>		16. SOCIAL SECURITY NO. <b>218-14-1120</b>		
17. INFORMANT ADDRESS <b>Joseph Watters 711 Nottingham Dr. 21001</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Aspiration</b> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>July 25 1985</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>1604 Shubertville Harford MD.</b>		
22a. I certify that (I) (this hospital) attended the deceased from <b>July 25 1985</b> to <b>July 27 1985</b> , that (I) (we) lost saw the deceased alive on <b>July 27 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)						
22b. SIGNATURE <b>[Signature]</b>		22c. DATE SIGNED <b>7/28/85</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>[Signature]</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-31-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harford Mem. Garden</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Aldino Harford MD.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Arnold W. Beard 353 Fountain St. Hd. Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 05 1985</b>		
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>						

MEDICAL CERTIFICATION

BP  
DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21-a is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 20286

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (a) (b) (c) <b>Philip W. Weber</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 27, 1985</b>		2b. HOUR <b>1 p.m.</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>FEBRUARY 17, 1931</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford</b> MD.	
10. CITY OR TOWN OF DEATH <b>Havre de Grace</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Harford Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ASST. VICE PRESIDENT</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>BANKING</b>
13a. STATE <b>MD</b>			13b. CITY OR TOWN <b>HARFORD</b>	13c. CITY OR TOWN <b>CHURCHVILLE</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>PHILIP WILLIAM WEBER</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>IRENE E. GOODMAN</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>KOREA 212 26 6160</b>		17. INFORMANT ADDRESS <b>MRS. ADELYN E. WEBER SAME AS #13e</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CAD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) <b>hypertension, diabetes mellitus</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 1984</b> to <b>July 1985</b> , that (I) (we) lost saw the deceased alive on <b>March 1985</b> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>L. Silverstein</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>7/27/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LOUIS SILVERSTEIN MD</b>		22e. ADDRESS <b>P.O. BOX 8, 203 S. WASHINGTON HAVRE DE GRACE, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1 AUGUST 85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HARFORD MEMORIAL GARDENS</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>ALDINO, HARFORD CO., MARYLAND</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078</b>			
25a. DATE REC'D. BY REGISTRAR <b>JUL 29 1985</b>		25b. REGISTRAR'S SIGNATURE <b>John F. ...</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 85 20281

1. DECEASED NAME (TYPE OR PRINT) <b>EDITH A. WELSH</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 31 1985</b>			2b. HOUR <b>12 <sup>22</sup> P.M.</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>APRIL 3, 1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford</b> MD.	
10. CITY OR TOWN OF DEATH <b>Havre de Grace</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Harford Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>	
13a. STATE <b>MD</b>				13b. COUNTY <b>HARFORD</b>		13c. CITY OR TOWN <b>ABERDEEN</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM A. RAGAN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARTHA M. ARRISON</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213 74 7984</b>		17. INFORMANT ADDRESS <b>MR. NELSON WELSH SR. 927 PARADISE RD. ABERDEEN, MO</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**CEREBRAL THROMBOSIS**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
**18 HRS**

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**arteriosclerotic heart disease & congestive failure**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <b>JULY 29</b> 19 <b>85</b> to <b>JULY 31</b> 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>JULY 31</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>B. J. Plunkett Jr. M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>7-31-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>B. J. Plunkett, Jr. M.D.</b>				22e. ADDRESS <b>Aberdeen, Md</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>3 AUGUST 85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BAKERS CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ABERDEEN, HARFORD CO, MARYLAND</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 6 1985</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 5 2 0 2 8 8  
REG. NO

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SCHLESY B. Wilson, SR.			2a. DATE OF DEATH MONTH DAY YEAR July 4, 1985		2b. HOUR P. 3:10 M.
3 SEX MALE	4 RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR MAY 18, 1899		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. CAROLINA	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.	
10. CITY OR TOWN OF DEATH JOPPA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 410 TIMBER LANE			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LOCAL 101	12b. KIND OF BUSINESS OR INDUSTRY CARPENTER
13a. STATE Maryland		13b. COUNTY HARFORD	13c. CITY OR TOWN JOPPA	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 410 TIMBER LANE 21085
14. FATHER'S NAME FIRST MIDDLE LAST BEVERLY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST WILSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 579 010456		17 INFORMANT ADDRESS FAMILY RECORDS	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF: (b) CHRONIC BRONCHITIS. DUE TO, OR AS A CONSEQUENCE OF: (c) C. O. P. D. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: A-S-C-V-D. PARKINSON'S DISEASE.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1982, 19, to 6-29, 1985, that (I) (we) lost saw the deceased alive on 6-29, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (and) did not view the body after death.					
22b. SIGNATURE Ruben S. Sebastian, M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED JULY 8, 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. RUBEN S. SEBASTIAN		22e. ADDRESS 2314 EAST JOPPA ROAD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JULY 8, 1985	23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE PARKVILLE BALTO. MARYLAND
24. FUNERAL DIRECTOR NAME EVANS CHAPLAIN OF MEMORIES		ADDRESS 8800 HARFORD RD.		25a. DATE REC'D. BY REGISTRAR JUL 11 1985	25b. REGISTRAR'S SIGNATURE The Davidson-Randall

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 REG. NO. 20289

1. DECEASED NAME (TYPE OR PRINT) Frances Marie Wooldridge Frances Marie Wooldridge				2a. DATE OF DEATH MONTH DAY YEAR July 20, 1985		2b. HOUR 6:55 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 1 1914		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.	
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machine Oper.	
13a. STATE Md.				13b. COUNTY Harford		13c. CITY OR TOWN Edgewood	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Deyak				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Malion			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 121-12-3404		17. INFORMANT ADDRESS Ronald Wooldridge (son) same address	

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOGENIC SHOCK</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <u>HEART FAILURE</u>		
DUE TO, OR AS A CONSEQUENCE OF (c) <u>ARTERIOSCLEROSIS -</u>		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

Acute Pulmonary Failure

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
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21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
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22a. I certify that (I) (this hospital) attended the deceased from 84 to 7/20 1985 that (I) (we) lost  
saw the deceased alive on 7/20 1985 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <u>Dante Monakil</u>		DEGREE		22c. DATE SIGNED 7/20/85	
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22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE MONAKIL, MD		22e. ADDRESS 6725 Union Ave Havre de Grace Md.	
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23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/24/85		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
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24. FUNERAL DIRECTOR NAME ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto. Md. 21213		25a. DATE REC'D. BY REGISTRAR 7/23/85		25b. REGISTRAR'S SIGNATURE	
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

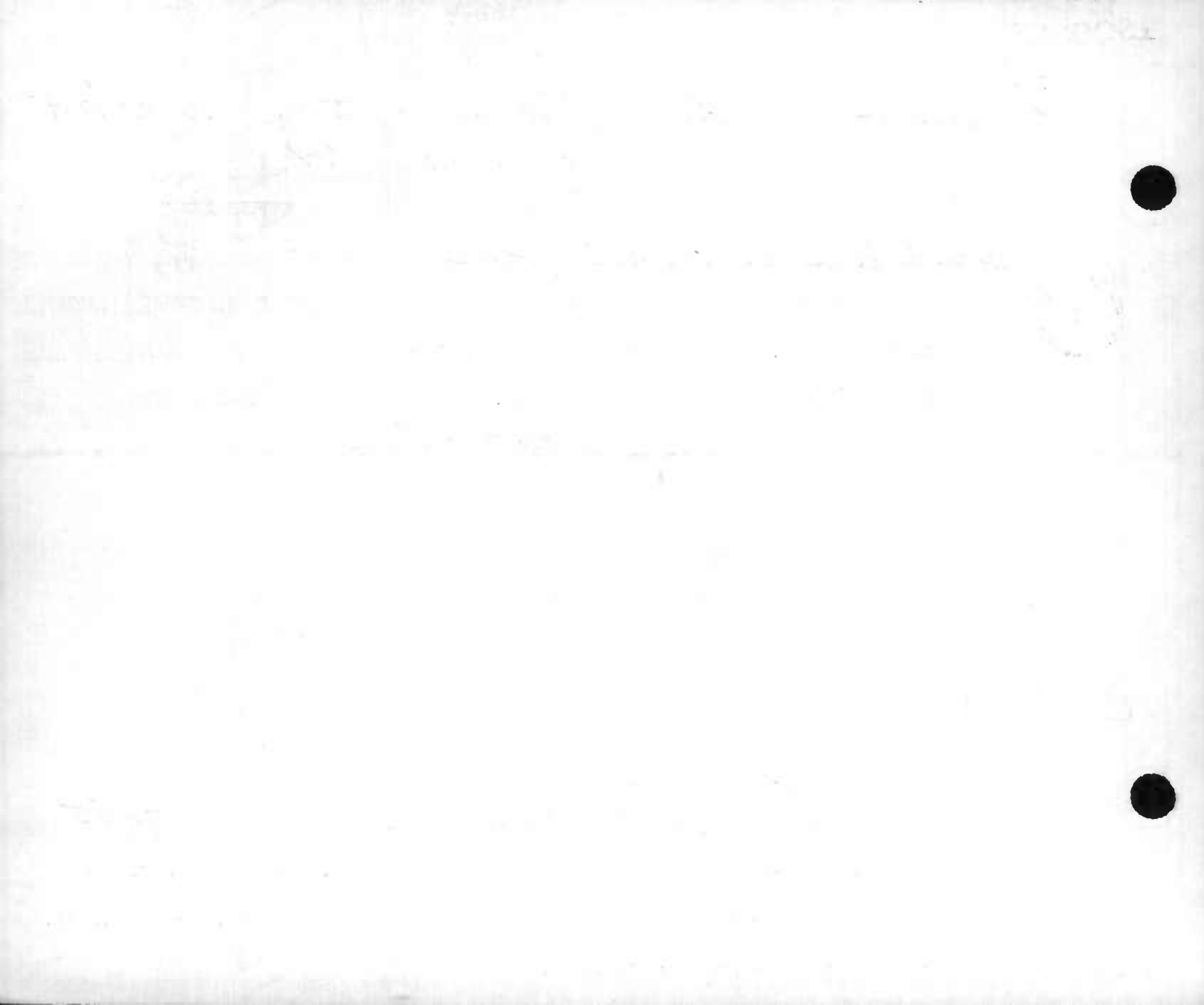
REG. NO. 85 20290

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Louisa L. Workman</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>July 10 85</i>		2b. HOUR <i>10:14 P M</i>
3. SEX FEMALE		4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR <i>1-11-11</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>74</i> YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.
10. CITY OR TOWN OF DEATH <i>Havre de Grace</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Breen's Nursing Home</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE MD		13b. COUNTY HARFORD	13c. CITY OR TOWN HAVRE de GRACE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ARTHUR G. WORKMAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LYDIA BELL		13e. STREET ADDRESS / ZIP CODE 410 NORTH STOKES STREET 21078	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 234 74 8864		17. INFORMANT ADDRESS MRS. JOAN COX SAME AS #13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) know the body after death.					
22b. SIGNATURE <i>[Signature]</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>7/11/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GUNTHER HIRSCH, MD		22e. ADDRESS 131 SOUTH UNION AVE. HAVRE de GRACE, MD. 21078			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 13 JULY 85		23c. NAME OF CEMETERY OR CREMATORY ANGEL HILL CEMETERY	
23d. LOCATION CITY OR TOWN COUNTY STATE HAVRE de GRACE, HARFORD CO., MD.					
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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JUL 12 1985



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

191056

1- FOR  
STATE  
REGISTRAR

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2029

1. DECEASED NAME (TYPE OR PRINT) SARAH GUNTHER WORRELL		2a. DATE OF DEATH MONTH DAY YEAR 7 4 85		2b. HOUR 8:34 P.M.	
3. SEX FEMALE	4. RACE CAUC.	5. DATE OF BIRTH MONTH DAY YEAR 5 9 08		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
10. CITY OR TOWN OF DEATH FALLSTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Realtor		12b. KIND OF BUSINESS OR INDUSTRY Realestate
13a. STATE MD.		13b. COUNTY HARFORD	13c. CITY OR TOWN BEL AIR	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 110 Brandywine Pl 21014					
14. FATHER'S NAME FIRST MIDDLE LAST George — Smith		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Zora — Greene			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) —		17. INFORMANT ADDRESS Gunter Md. 21014 Mrs. Betty Smith Jones, 1 Glenwood Road, Bel Air,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MASSIVE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) coronary occlusion DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
21g. I certify that (I) (this hospital) attended the deceased from 7/4 1985, to 7/4 1985, that (I) (we) lost the deceased alive on 7/4 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22a. SIGNATURE BARBY A. WOHL		DEGREE MD		22c. DATE SIGNED 7-4-85	
22b. ADDRESS 2003 Rockspan Rd. Forest Hill, MD 21050					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 8, 1985		23c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran Cemetery, Joppa, Harford Md.	
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009		24b. ADDRESS		24c. DATE JUL 8 1985	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

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